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MENTAL HYGIENE aims to bring dependable information to every one whose interest or whose work brings him into contact with mental problems. Writers of authority present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public are republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology are presented and discussed in as nontechnical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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JULY

OCTOBER

MENTAL HYGIENE

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THE CONSTRUCTIVE USE OF PUNISHMENT

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PUNISHMENT, the infliction of retributive suffering or deprivation, is an ancient method of seeking to modify or control human behavior. It has been more abused than any other method of human control. This abuse occurs because of the ease with which punishment can be applied—without the painful necessity of thinking—and the sense of status, righteousness, and emotional release it gives the indignant guardian of right who administers it, serving in this way to permit him to maintain more comfortably the balance of his own inhibitions. Another factor in its abuse is the occasional appearance of a sadistic enjoyment of punishing.

The widespread misuse of punishment and the cruel manner in which it is often applied have resulted in a reaction against it as a means of influencing human behavior. Particularly in the mental-hygiene movement, many have reacted so strongly against punishment as to challenge its having any constructive place in the techniques of human control. These emotional reactions to the abuse of punishment have frequently tended to obscure a clear recognition of its usefulness and necessity. Many people tend to think of therapy and punishment as necessarily contradictory. They may find punishment necessary, but they must rationalize it as something else. The result has been confusion, vacillation, and distorting rationalizations in an area in which clear thinking is needful.

It is the contention of the present writer that children cannot be socialized without a discerning use of punishment,

and that a society cannot exist without sanctions of punishment.

No system of control that relies exclusively or primarily on punishment can produce a socialized individual. Socialization cannot be based primarily upon fear. It depends upon the experience of being accepted, loved, and cared for, which leads to the development of the capacity for reciprocal affection and loyalty, for the willing sacrifice of some of one's desires for others. As long as an individual's conformity is based solely on fear, we cannot call him socialized. We could not trust him in a blackout. Punishment judiciously used will serve to reënforce, and to make effective, limitations set upon conduct. By itself it never produces socialization. Love and affection are necessary to socialization. Love and affection are rarely promoted by punishment.

The reverse of punishment is reward, and while this paper is not primarily concerned with reward, some consideration of it cannot be avoided. Some type of reward for commendable behavior will be prominent in any system of socialization. As a child becomes more mature, the rewards to which he is most responsive will shift from the level of physical gratification to more socially expressed love and affection, and to social approval of his behavior. The socialized individual will find his adequate reward in the social response and approval his conduct brings.

Although reward will be the center of any program of socialization, punishment will be necessary to define limits. The material reward that can be offered to all members of a group for conformity is often less than any can secure from nonconformity—for example, from large-scale stealing. The reward of social approval may not balance, in a materially-minded individual's judgment, the advantage to be gained by such nonconformity. Here the motivation of reward may break down unless the reward is increased. Offering to an individual special rewards, material or social, which cannot be offered to the group, for conforming to what is already expected of him, rapidly becomes blackmail, for it puts him in a position to exact his own price for refraining from antisocial behavior. For this reason it is impossible always to maintain conformity without resort to punishment.

Reward can be offered the individual in only limited amount. In the event of necessity, punishment can be offered more generously.

It would be a gross distortion of fact to suggest that it is primarily punishment that keeps people law-abiding. Socialized people have incorporated inhibitions within themselves. There are, however, situations involving human behavior in which limits have to be drawn, either because inhibitions have not yet been implanted or because changed conditions require altered limits. Punishment is one of the methods of drawing limits. Sometimes it is the only method sufficiently available for use.

What might be called the functions of punishment may be discussed under two headings. These are (1) the control of behavior, and (2) the release of tension or anxiety.

The Control of Behavior.—The control of behavior through punishment can be effected through any one of three dynamisms, or any combination of them. These are: (1) the direct fear or dislike of the pain or unpleasantness of punishment; (2) the development of controls within the individual; and (3) the establishment or maintenance of social or group taboos.

1. The simplest level on which punishment can be used effectively is the level of the direct fear or dislike of its pain or unpleasantness. This is the level used by the animal psychologist in rat experiments. It is the level of control used with the very young child. The behavior of adults is complicated, yet this level of control easily operates even with adults in areas in which they have no strong value reactions either to the conduct punished or to the social significance of the punishment. A further condition for its success is that they do not accept the punishment as a challenge. If socialized adults feel the punishment as a disgrace, this fact is usually far more persuasive than the mere unpleasantness of the punishment.

If punishment is relied upon to control the behavior of adults in directions that run counter to their dominant attitudes or loyalties, it is generally ineffectual unless it is so severe as to create a reign of terror. Terror is destructive of practically all of the values of our social life. That it can

have a limited effectiveness in controlling behavior cannot be denied. Obviously, in a democratic nation it can be justified as a means of social control only in a most extreme and limited emergency. Under such circumstances it may be less destructive of democracy than its possible alternatives—*e.g.*, large-scale sabotage.

2. From any long-range point of view, our objective is not simply to achieve external control of behavior of a dangerous or socially destructive sort, but also to develop inhibitions against such behavior within the individual. There is, too, the need for internalizing a sense of positive obligation to do certain necessary things. These effects can be achieved in a dog and appear to depend upon the capacity of the dog for an affectional tie. Punishment alone is not an effective method for developing internal controls. Indeed, it may operate in a precisely reverse direction if the punished accepts it as a challenge.

Punishment as one—occasionally and judiciously used—method in a child-training program may contribute significantly toward the development of inner controls, or of what is conservatively called character. Indeed, if deliberate punishment is not used in this process, some other method of deprivation and frustration—which in fact constitutes an essentially punishing experience for the child—inevitably will be used. From this point of view the discussion of dispensing with punishment becomes nonsensical, for as frustration, limitation, and the experience of unhappiness at the hands of others because of disapproved conduct, punishment is an inescapable experience of social life. If punishment is to have a constructive effect, however, it is essential that the child feel loved, or at least accepted, and be able to recognize the punishment as a limited disapproval of some limited and modifiable aspect of his behavior. If the child interprets the punishment as a result of a general and lasting dislike or hostility from the people on whom he is dependent for love and security, it will inevitably have a destructive effect.

This brings us back to the fact that any system of control that relies primarily upon punishment can never develop controls within the individual. Such restraints can be effective only so long as they are inexorably enforced from the

outside, after the manner of the traditional discipline of the prison. A primarily hostile punishment may sometimes have a constructive effect, but only if it is a not-too-bitter experience at the hands of some one on whom the child is not dependent for love and affection. Even in such a case, it is not likely to be constructive unless interpreted to the child by an understanding adult.

3. The third way in which punishment may be effective is through the reaffirmation of an accepted taboo or the establishment of a new one. It requires much more than one instance of punishment to establish a new taboo. New social taboos cannot, however, be established without the use of punishment. A social group may reaffirm an existing taboo by a single instance of punishment of its violation.

Personally, I like to drive my car. Most of us conceive that to sacrifice car driving is a very limited personal sacrifice in the nation's present peril. Yet most of us are selfish enough, or envious enough, or human enough to feel that if this minor sacrifice is demanded of us, the same sacrifice should be asked of others. If we see others, without justification, consuming the extra gasoline and rubber that we deny ourselves, we have a sense of injustice and indignation and here we exhibit a characteristic human reaction. If we sacrifice to the common good, others must sacrifice also. If some take advantage, they must be punished—or for what right principle are we sacrificing?

Here one can see the function of punishment in the assertion of morality, the establishment or maintenance of social taboo. If we see others flagrantly violating the rationing with no good reason, and nothing is done, it raises the question why we should deny ourselves. Are we patriots—or merely suckers? To establish ourselves as patriots rather than suckers, we must check or punish the ration violators, who are otherwise making suckers out of us by selfishly profiting from our sacrifices.

If we see another violate an older and more established taboo, such as the taboo against murder, we respond perhaps only with indignation. If some one suggests that we want to be free to commit murder, too, we indignantly deny it. Yet have we not half-consciously wanted to murder some one

now and then? The same dynamism that is exemplified above in the case of rationing operates in the righteous indignation the public shows against the criminal. Even though our own impulses to crime may have been effectively repressed, they stir in the dark and disturb us when we contemplate unpunished crime. This is an important factor in righteous indignation. Public morale can be easily maintained only as long as there is some faith that crime will be punished. If I do not see it done in this world, I may comfortably preserve my own repressions if I have sufficient faith that it will be punished in the next.

The Release of Tension or Anxiety.—It follows from the foregoing that one function of punishment is to relieve tension in the individual or the group that disapproves the punished act, by exacting payment for it through punishment. This function is one of the great causes of the abuse of punishment, since punishment is commonly determined by this function, with its other effects not considered or not adequately considered.

Punishment also may have a function in relieving tension in the punished. The offender may be in a destructive state of self-accusation which may be relieved by punishment, and he may thereby be freed for a more constructive social adjustment, if the self-condemnation has been excessive. We must, on the other hand, recognize that the punishment may in itself increase the offender's consciousness of his offense and produce in him a sense of rejection or ostracism by the community. It will be the elements surrounding the application of the punishment and the make-up of the punished that will determine which of these two reactions will occur.

We must also recognize the possibility that the offender who is slightly troubled by his conscience may be given an untroubled conscience by being punished, or may even develop a hostile, bitter attitude as a result of the application of punishment that he considers arbitrary, capricious, or excessive. We may even conceive that an individual may seek an excessive punishment to free him to commit forbidden acts without protest from his conscience. Certainly many individuals use their own hardships or sufferings to justify their aggressions toward others. Punishment may

in this fashion interfere with a process of self-control that would otherwise develop.

Misuses of punishment not related to its functions may occur if it is used for the assertion of dominance over others, or for the destructive expression of hostility, or for the sexual stimulation or gratification that the sadist may find in the infliction of pain or suffering.

We must recognize that individuals sometimes punish themselves or seek punishment at the hands of others. This may be for the release of tension because of self-accusation; it may be from the masochist's sexual enjoyment of pain or humiliation; or it may be, consciously or unconsciously, to pay past social debts or to secure a grievance that would justify aggression toward others. The effect of punishment is determined by the immediate situation, the general life situation of the punished, and his personality development. Broadly speaking, reactions to punishment may be classified under five headings: (1) Indifference, (2) Disorganization, (3) Hostility and Counter-aggression, (4) Acceptance of Limitation or Social Adaptation, and (5) Acceptance of Punishment Without Acceptance of Limitation.

1. Indifference. Real indifference can scarcely be called a reaction. It is rather a lack of reaction. Most instances of apparent indifference, however, are not real indifference. They represent a cultivated technique of counter-aggression designed to deny the punisher the satisfaction of the response he is seeking; consequently they belong under the third heading of this series. This technique is seen at its height in the indifference that the American Indian traditionally showed in the midst of torture by his enemies. The most effective weapon of counter-aggression within his power was simply his refusal to admit that his captors were capable of hurting him. For precisely the same reason, some children will refuse to cry when spanked, or will actually laugh despite rather severe punishment. Most apparent indifference to punishment is a cultivated defense.

2. Disorganization. The reaction to punishment may be confusion, anxiety, excited and undirected effort, or paralyzing fear. Particularly if the punishment is severe or unexpected, or if it appears to the punished illogical or unpre-

dictable—especially if it runs counter to previously enforced rules of conduct—a disorganization of behavior or even of personality may follow. To profit from punishment requires a learning process involving discrimination, planning, and the clear recognition of taboos. Punishment of a severity that is acutely disturbing, occurring in a situation that creates doubt as to whether or how it may be avoided, is likely to disorganize. Excessive fear of punishment may have the same effect.

3. Hostility and counter-aggression. Since punishment is a form of aggression, or of counter-aggression, it arouses the impulse to further counter-aggression. As repetition of the forbidden act or the performance of other forbidden acts is often a convenient and accessible form of counter-aggression, punishment that brings the response of hostility and counter-aggression will often have an effect almost precisely the reverse of that desired.

4. Acceptance of limitation, social adaptation. The response to punishment may be the acceptance of the limitation that the punishment is intended to sanction. This involves a learning process and an adaptation. This adaptation may be inadequate or excessive. If inadequate, further training will be necessary. If adequate, the learning process has been successful, for the time being at least. If excessive, it may tend toward the disorganization noted above, or it may tend toward an overlimitation of behavior such as is seen in the inhibited personality.

5. Acceptance of punishment without acceptance of limitation. Punishment, particularly when it occurs only occasionally for a given offense, may be accepted without adaptation, as a part of the fortunes of living. No effort may be made to avoid it, or the effort may be only in the direction of seeking to be more clever in committing offenses. This latter attitude is typical of the professional criminal. It is seen also in the child who is confused or discouraged by the maze of social limitations imposed upon him. It occurs, too, when the punished person values what he gained by his offense more than he values the risk of punishment.

Many factors enter into the determination of which or what combination of these reactions may follow punishment. Some of the factors are the following:

1. The sense of acceptance or emotional security left to the punished person. Social adaptation of a constructive sort will occur only in the individual who has some sense of being accepted and secure in the interest, respect, and affection of others. The attitude of those who punish him is important, although if he has sufficient security elsewhere, he may be able to respond constructively even to a hostile punishment. The attitude of those family members and intimates to whom he looks for acceptance is of crucial importance. Without this sense of acceptance, his reaction will be one of counter-hostility, or disorganization, or both, depending in part upon his capacity to nourish his spirit on relations of hatred rather than of affection. With a sense of acceptance, the reaction to punishment is likely to be adaptation.

Here we see the greatest factor in the failure of our punitive justice—the fact that it is associated with more or less lasting social rejection of the punished by the conforming. The reputation that military discipline traditionally has for "straightening up" young men doubtless stems in part from the dependability of military discipline, but probably more from the fact that punitive measures are used unhesitatingly and consistently, but without great readiness to reject the punished person. The soldier who has been in the guard house is usually better accepted by his comrades on his release than is the civilian who has been in jail.

This sense of acceptance is of course subjective and depends upon the personality and mental state of the punished as well as on the external situation. The young child will regard punishment as aggression and react with fear or hostility. It is only when the parent continues to satisfy the affectional needs of the child, and relates the punishing experience to some special type of behavior discernible by the child, that the latter gradually comes to recognize that punishment does not necessarily imply hostility. The child-guidance clinics and the training schools for delinquent children see many children by whom punishment always is interpreted as hostility and whose response to punishment is always counter-aggression rather than adaptation. Such children require great acceptance, much evidence of the

adult's interest in them, and often clear evidence of the adult's superior power as well, before they are able to accept correction in even the smallest doses without reacting with aggression. On the other hand, children who have been well trained and well socialized will respond to an understanding and reasonable application of limitations, backed by punishment where necessary, by an acceptance of the limitations and an adaptation. Security in emotional relationship gives the individual some capacity to accept frustration and punishment.

2. The clarity of the prohibition to the punished. If a prohibition is to be effective, it must be understood. If it is not clear, there will be a reaction of irritation or of anxiety, depending upon the personality, and the response is likely to be one of counter-aggression, or of acceptance of punishment without acceptance of the limitation, or even of disorganization.

3. The reasonableness of the prohibition to the punished. If the prohibition is consistent with other prohibitions familiar to and more or less accepted by the punished, he will be the more likely to respond with adaptation. If it appears to him unreasonable, capricious, or unfair, he is the more likely to respond with counter-aggression or acceptance of punishment without acceptance of limitation, or to be disorganized.

4. The severity of the punishment. Very mild punishment may be easily ignored. The reaction may be true indifference or acceptance of punishment without acceptance of limitation. Very severe punishment is likely to result in disorganization, particularly if there are other factors contributing in this direction, such as lack of clarity or understandability in the prohibition, or inconsistency in its enforcement. Mere severity will never insure that the limitation imposed by the punishment will be accepted. Severity is a relative matter. The point is that the punishment must stand out by contrast with the rest of living. Those who are inured to hardship and a harsh life may not be readily deterred by physical pain *per se*. Those who must constantly face the risk of death may be little deterred from offending by a further risk of death *per se*. Either, on the other hand,

may be very sensitive to the punishment of disapproval by their comrades, if accustomed to receiving their acceptance or approval.

5. The reasonableness of the type of punishment to the punished. A type of punishment that appears reasonable to the punished is likely to bring about adaptation. A punishment that appears inappropriate to the punished is likely to result in counter-aggression or even disorganization. Public ridicule and humiliation as punishments are likely to provoke counter-aggression in our culture. They are much used in certain primitive cultures, as among the Eskimo.

6. The consistency with which the punishment is applied. Consistency is of major importance in determining adaptation. Application of punishment to one offender, if other known offenders are let off with less punishment or without punishment for no acceptable reason, is likely to be regarded as personal aggression. It may provoke counter-aggression or discouragement and acceptance of punishment without acceptance of limitation. Inconsistency in the application of punishment to the same individual over a period of time promotes the tendency to accept the punishment without accepting limitation, or even to respond with disorganization.

7. The sense of the punished regarding the penetrability of the limitation or the conquerability of the force behind the punishment. If we bump our heads against a stone wall, the initial reaction is likely to be one of wanting to kick the wall, to exert counter-aggression. If we yield to this temptation, we soon cease this method of attack because we realize that the wall is there, that it is solid, and that we are wasting our time in attempting to attack an unyielding limitation. If, instead of a wall, it is a swinging door we bump into, we will be under a greater temptation to kick the object, and if we do, and it swings back and strikes us again, or even swings in our direction, there will be more temptation than in the case of the wall to continue the combat.

As adults, we realize that the swinging door, like the wall, is behaving according to certain inexorable laws of nature, and we will certainly not continue the contest long. If, on the other hand, some other person intentionally bumps into us, we will have more impulse toward aggression than in the

case either of the wall or the swinging door. In each case, the pain and the pain-stimulated emotion may have been the same, but in the case of the wall, we have learned that counter-aggression is not an intelligent way to meet the situation and we suppress our anger. On the other hand, when some one intentionally bumps us, we are likely to bristle in the expectation of further aggression or conflict, and our anger flares up.

In the same way with respect to the limitations set by punishment, the question of how appropriate counter-aggression is in the experience of the individual will determine to a great extent what his attitude will be. If the penalty is well-known and impersonally applied, he is likely to accept it, although if he has consistently had the experience of being able to penetrate limitations through counter-aggression, it will be natural for him to attempt this.

Most of us have—since life requires it—a considerable willingness to take a chance. It is for this reason that severity of punishment is a much less effective deterrent than certainty of punishment. Individuals who are not grossly denied satisfaction in their whole life adjustment will rarely rebel consistently in the face of overwhelming force. This is a reason for the success of military discipline, which restricts far more than does the discipline of civilian life, but which comes to be accepted by most soldiers, in certain of its phases at least, as being as rigid a limitation as a stone wall.

One's sense of the penetrability of a limitation changes one's attitude toward it. If a small boy wishes to steal a banana from a fruit stand, he will be less likely to do so if a policeman is standing by the fruit stand than if the policeman is three blocks off. Furthermore, he is likely to feel that it is a worse offense to steal the banana if the policeman is there than if the policeman is three blocks away—and the policeman will probably share this judgment, at least to the extent of feeling the one offense is much more deserving of punishment than the other.

8. The effect of group attitudes. Since we live in a society, group attitudes are of tremendous importance in determining the individual's attitude toward punishment. When a limi-

tation of behavior, contrary to the loyalties and self-accepted taboos of a group, is imposed upon the group, a conflict situation is inevitable, and the group tends to support the offender against the outside authority. The situation in the countries of Europe under Nazi occupation is an illustration in point. The problem of reconciling two groups with differing sets of values can be met under less drastic circumstances by degrees of conciliation, compromise, and bargaining. When, as in the case cited, there is, on the part of the submerged population, extreme bitterness engendered by past aggression, insecurity on the part of the dominant group, a chasm between viewpoints, and not only an unwillingness on the part of the dominant group to make any concession, but an unwillingness that is reënforced by an absolute moral position that forbids concession as a betrayal of national superiority, and that glorifies control by force, it is inevitable that control will be by terror. Here we return to the misuse of punishment at its worst. Group support of the punished will, if he survives, incline him away from adaptation and toward counter-aggression; or if this is overwhelmingly difficult, toward the acceptance of punishment without acceptance of limitation. Group support will tend to protect him from disorganization.

When we consider terror, as applied in the Nazi-occupied countries, the methods of punishment broaden by being released from any subservience to our sense of justice. Methods of terror pass over from punishment of the offender to the punishment of the whole group to which the offender belongs, to the punishment of relatives or others dear to the offender, and to the punishment of hostages. All these last are in increasing degree repugnant to our sense of justice, although school authorities sometimes still make use of group punishment for the action of an unknown offender. Other cultures have had different conceptions of justice. Under the Code of Hammurabi, if a house fell and killed the son of the householder, the son of the architect was put to death. The infliction of a death penalty on the child of the offender is to us injustice; in ancient Babylon it was simply retributive justice.

Group punishment is commonly used in an effort to bring pressure on the group to restrain or punish the individual

members who offend. If the group is in sympathy with these members, group resistance may be expected, and even the methods of terror may have little effect.

While group punishment, including penalizing the innocent for the sins of the guilty, offends our sense of justice, group rewards—which necessarily include benefits for the undeserving in the group—do not offend us. This equality of reward for unequal contribution is partly compensated by the enhanced position in the group usually awarded those who have contributed conspicuously to the winning of a group award, and to the reduced position of those who have not contributed.

THE CONTRIBUTION OF ADOLF MEYER AND PSYCHOBIOLOGY TO CHILD GUIDANCE

ETHEL KAWIN

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IN 1892 a young Swiss doctor in his twenties turned his face toward America and sailed westward to seek a medical career in the United States. He wanted to practice and to do research on the brain. In the New World this young man eventually became the accredited representative of American psychiatry, and is generally referred to to-day, respectfully and affectionately, as "the *dean* of American psychiatry." The name of this young man was Adolf Meyer.

One reason for writing this article is that Adolf Meyer's contribution to the field of child guidance is not an obvious one. His is not one of the names outstandingly associated with child guidance, nor has he officially headed any such organized movement. Those who have followed the growth and development of child-guidance work in America, however, recognize the major contribution made to the movement by Adolf Meyer, both in the very nature of the psychiatry that he established, which became outstanding in this country, and in the early clinical work with children, for much of which he was directly responsible.

Such an evaluation of Meyer's basic contribution is found in the chapter on psychiatric theory in Helen Witmer's book, *Psychiatric Clinics for Children.*[1] She describes three main groups of psychiatrists in America in the early 1900's who were interested in psychological questions. The first group followed Freud; the second was headed by Boris Sidis and Morton Prince; and the third by Adolf Meyer. Of Meyer, Witmer says:

> "His point of view was less theoretical than the others and put much stress upon 'common sense'—a fact that may account for the more ready acceptance which his work received. However that may be, it is clear

[1] New York: The Commonwealth Fund, 1940. Chapter I.

> that it was he who was chiefly responsible for turning American hospital psychiatry away from physiological studies to an interest in the total human being. In their several ways, then, these three groups of men and their followers brought to the American public some conception of the potentialities and dangers of childhood and made the further development of child psychiatry inevitable. . . . Meyer has remained the dean of American psychiatry, the original source of inspiration of many workers in the field of child psychiatry, and the binding link between diverse schools of thought."

Meyer's insistence upon studying *the total individual,* and his emphasis upon study of the *life history* of that individual, in the belief that in it will be found the causes of mental difficulty, established an approach to the study of personality and behavior that became characteristic of sound guidance work in this country. This approach—formulated in his early work at Kankakee, and developed in his later work at Clark and Cornell Universities—found its fullest expression in his long and distinguished service as head of the department of psychiatry at Johns Hopkins. It is known as the *psychobiological* approach. Dr. Meyer was one of the first psychiatrists to see and to point out the close relationships between mental disease and childhood experiences, not only in the home and family situation, but also in the school and the larger community.

Meyer's Professional Training and Experience.—Adolf Meyer was born near Zurich, Switzerland, on September 13, 1866. The son of a Zwinglian minister of the Zurich State Church, and the nephew of a capable physician in a semi-industrial community, he enjoyed the training of the "folk-school" and the gymnasium. Born and reared on the border of a Protestant region adjoining a Catholic canton, with the former enclosure of the Jewish community of Switzerland nearby, young Adolf grew up with tolerance and a wholesome curiosity concerning human similarities and differences. When facing the choice of a vocation and weighing the relative opportunities offered by the church and by medicine, he decided in favor of the latter as offering the greater opportunity to work with the whole of man rather than only part of him.

Adolf Meyer completed his medical studies at Zurich, and attained the right to practice by passing the qualifying state examination in 1890. Two years of fruitful postgraduate

study brought this receptive young physician into contact with the teachings available in Paris, London, Edinburgh, Vienna, and Berlin. In these great medical centers, as at home, he met men and ideas that were to become important factors in the formulation of his own psychiatric foundations, methods, and opinions. While increased knowledge in the anatomic and clinical fields was the immediate objective of his studies, young Meyer, from the beginning of his work, was constantly seeking some framework of thought within which he could assimilate divergent views of physicians, psychologists, biologists, and philosophers in regard to the nature and place of human experience in the world.

His medical studies abroad culminated in the decision to make his career in the New World, and he came to the newly opened University of Chicago in 1892. Meyer's earliest professional interests were in the research areas of anatomy and comparative neurology. His doctoral thesis was on the structure of the forebrain of reptiles. When he took up his residence in Chicago, this still was the direction of his first work. In 1893, as docent in neurology at the university, he conducted an elective course in the comparative anatomy of the nervous system, and the next year he gave the regular course in the anatomy of the brain.

These research and teaching activities were broadened by meeting the more practical demands of life in medical practice and in an appointment as pathologist at the Kankakee State Hospital. Young Meyer had originally avoided psychiatry as a field requiring a greater facility of verbal expression than he felt able to furnish, but his medical practice in neurology soon brought him into that field. Through Dr. O. Krohn, psychologist at the University of Illinois, young Meyer became a member of and a contributor to the early Illinois Association for Child Study founded by Krohn. Through these contacts he made others with such leaders as Colonel Parker, Jane Addams, Julia Lathrop, and others interested in the education and welfare of children.

Meyer left Illinois in 1895 to pursue the larger opportunities offered him at Worcester State Hospital in Massachusetts, first as pathologist and later as clinical director. As docent in psychiatry, he also taught graduate students in

psychology and biology at Clark University. After seven very productive years there, Dr. Meyer was appointed Director of the Pathological Institute (later the Psychiatric Institute) of the New York State Hospitals for the Insane. While holding this post, he taught at Cornell Medical School. The eight years in New York City were years of continuous development and productivity as physician, teacher, and research scientist. Dr. Meyer's work extended beyond the institute and the medical college to "beginnings" in the more general field of *mental hygiene,* which later grew into a widespread and significant movement.

By 1908, when Mr. Henry Phipps announced his generous donation to the Johns Hopkins Hospital for the establishment of a psychiatric clinic, Adolf Meyer had become an outstanding leader in American psychiatry and was the obvious choice for director of this promising pioneer venture. With this new position came appointment to a professorship of psychiatry in the Johns Hopkins University School of Medicine, with residence in Baltimore.

The clinic was opened in 1913. In 1937 a special celebration was held in Baltimore in recognition of a twofold occasion—the twenty-fifth anniversary of the Phipps Psychiatric Clinic and the seventieth birthday of Dr. Meyer. The Board of Johns Hopkins Hospital refused to accept Dr. Meyer's resignation at that usual retirement age because they felt that he could be neither spared nor replaced. Adolf Meyer remained the active head of one of the most important centers for psychiatric teaching, research, and treatment, until 1942.

Contributions of Adolf Meyer.—The contributions of this remarkable personality, in the course of a long, energetic, busy life have been manifold. In addition to his many and varied activities, Dr. Meyer has written for professional journals continuously since 1891. A complete bibliography of his published articles includes nearly two hundred titles. His work during his long, distinguished career could be evaluated from many different points of view. The writer, not being a physician, would not attempt to evaluate it in any of its medical aspects. This discussion will be limited to Dr. Meyer's contributions in relation to only one particu-

lar field of work, but a very broad field—that of child guidance.

First, we shall want to analyze the nature and characteristics of his whole approach to the study of human personality and behavior, known as psychobiology, because it has profound implications for the development of child guidance in America. We shall want also to consider Dr. Meyer's early and lasting interest in childhood and in the training and education of children. His recognition of the significance of life's early periods and experiences has played an important rôle in arousing the interest in childhood that led to organized movements in child guidance.

Psychobiology.—Through all his long career, Adolf Meyer has made no pretense of developing a "school" or a "system" of psychology or psychiatry. In facing the enormous complexities of human personality and behavior, he has always been ready to adopt or to adapt any contribution that sheds light on these complex processes. The *psychobiologist* is a scientist who accepts the truth regardless of its source and is willing to follow any promising procedure irrespective of its name. He is ever ready to accept from any worker or any "school" that which has been satisfactorily proved to be a factual contribution. Psychobiology insists upon remaining free from any mystical concepts. It works with concrete, objectively demonstrable facts, obtained in an unprejudiced, critical, and self-critical manner. In the study of personality, the psychobiologist is unwilling to consider any selected group of facts as the only valid ones or as all-important.

Dr. Meyer accepted early the fact of *multiple causation.* Results obtained through research in child development during this past quarter of a century have consistently supported this point of view. A particular manifestation of behavior or personality usually does not appear to be the result of any single factor in the make-up, environment, or experience of an individual, but is rather the result of a "constellation" of such factors, which, in combination with one another, tend to produce the observed result.

Psychobiology is definitely a *pluralistic* science—a democracy of the sciences in which none is allowed to pose as

making the others unnecessary. It includes in its study physical, intellectual, conative, affective, and situational factors. It utilizes the contributions of all related sciences—anatomy, physiology, neurology, chemistry, pathology, psychology, sociology, and anthropology. It is intensely interested in *facts* of any kind, Meyer specifying as *fact* "anything the presence or absence or operation or non-operation of which makes a difference."

Psychobiology regards man as a psychobiological unit or integer of body and mind and what throughout the ages has been called the soul, forming the "he" or "she" living within a changing and changeable environment. It attempts to study the *whole individual* in the *total life setting.* Meyer early took a stand against bifurcation and parallelisms of body and mind, as well as against monisms that emphasize either body or mind. He has always regarded body and mind as an integrated whole, psychobiological behavior being a function of the total organism. This psychobiological unit or organism with which the psychobiologist deals is the feeling-thinking-acting *person,* the living individual as he is in his daily life and environment, busy with his work, adjusting to his family, friends, and fellows, seeking his pleasure and his rest, developing, growing, creating—in short, the functioning individual as we observe him in his work, his play, his rest, or whatever else may occupy him in the experiences of his specific life cycle.

To study and understand such an individual, the psychobiologist proceeds with critical common sense to observe and to study concrete performance. General impressions will not suffice, nor will just the subject's own account of his history and difficulties be adequate, although such material is a valuable part of the information gathered. It is in the emphasis upon actual observation of the individual in the usual concrete performances of his daily life that one finds one major difference between psychobiological and psychoanalytic method. This is one important aspect of psychobiology's contribution to our modern work with children. The general procedure or outline of inquiry that guides the psychobiological approach is: *What are the facts? Under what conditions do they seem to arise or occur? What are*

the factors involved and at work? How do they manifest themselves? In what way do they operate? With what results? With what modifiability? What means of modifying them can be found and wisely utilized?

In actual work with children in homes and schools, this approach provides a sound foundation, a scientific, objective procedure based on common sense; it provides a method of dealing with the realities of life in ways that make some degree of amelioration possible in almost every case and in every type of situation.

Psychobiology is a genetic-dynamic science. It starts with the *here and now* of the available data and matters of concern. It strives to ascertain the origins, to understand the evolution, and to consider the possible future development of the personality and behavior with which it is concerned. All of this involves the study of the *life history* of the individual one seeks to guide or help. Within the setting of that life history, the psychobiologist turns frankly to consideration of specific items.

To understand an individual, one needs a balanced knowledge of his physical and psychological make-up, with its assets and limitations, of the stock from which he was born and the setting in which he grew up. One needs a reasonably full life history of the events and influences that may have been significant factors in determining that individual's own development, adjustments, or maladjustments. Only upon the sound foundation of some such thorough knowledge of and respect for any individual can one hope to foretell within reasonable limits what can be expected of that person. One needs to understand what can reasonably be expected of him in regard to health, happiness, efficiency, and achievement, in terms of specific tasks and situations, in order to help any individual to satisfactory adjustment. Increasing recognition of this point of view in modern education has greatly improved our guidance of children and youth, both in schools and outside.

Toward all problems the psychobiologist advocates a melioristic, plastic attitude. He makes no pretense of having panaceas; he does not expect cure-alls. There is nothing of the "Pollyanna" about his sober, scientific attitude, but

every problem constitutes a challenge, and no personal or social condition is regarded as hopeless; some worth-while effort to ameliorate it can always be made.

How does the psychobiological formulation differ from those of the so-called "schools" of psychology, such as psychoanalysis, individual psychology, and the like? Each of these schools finds some more or less universal pattern in human behavior. Each claims to have discovered the underlying mechanisms of adjustment and maladjustment through which the riddle of human behavior can be solved. Whether the underlying motivation be regarded as sex drive, drive for superiority, or some other, the interpretation of individual behavior is in each instance reduced to a single basic cause or set of causes. Certain patterns—certain causes—are to be sought and found in most, if not all, of the cases that one studies.

It is quite different when a psychobiologist studies an individual case. An effort is made to investigate thoroughly all relevant factors. The study may start with the "problems" of the individual who is being studied. All possible relevant facts, present and past, are gathered. There are no preconceived ideas as to what forces have influenced that particular individual's delvopment. The psychobiologist stands ready to accept and to use any factual contribution for which there seems satisfactory evidence and that seems pertinent to the issues at stake. None of the factors regarded as significant by any "school" or group of workers in any related field lie outside the realm of his consideration in any case. The interpretation in each case is based upon observations and findings, gathered with the greatest objectivity possible.

This open-minded objectivity, including all accessible subjectivity and symbolization or mentation, has always characterized the work of Adolf Meyer. He has been friendly, but challengingly critical toward all new methods, theories, and experimental work. Because of this he was the first psychiatrist in this country to show a friendly and professional appreciation of psychoanalytic concepts. He expressed this in his first (unfortunately lost) paper read before the Chicago Pathology Society, February, 1893, long before

Freud and Jung first presented their concepts in this country in 1909. An early student of Meyer's, H. H. Goddard, introduced the Binet Scale for testing intelligence into this country, and Watson's early formulations of Behaviorism were further developed in the laboratories of Phipps Clinic.

With an open door to critical common sense and genetic, dynamic attention to meanings and their rôle and influence, the psychobiologists give a hearing to every new contribution in any field that might illuminate the study of human personality and behavior. It is interesting to note that one of the most helpful books for parents and teachers published in recent years[1] finds in this principle of multiple causation of Adolf Meyer's psychobiology a sound basis upon which educators may build programs of pupil adjustment.

Meyer a Trail-Blazer.—It is important to remember that the basic concepts Adolf Meyer used in the study of mental problems were a great departure from the generally accepted psychiatry and psychology that surrounded him during his early years in America. The major interest in mentally disturbed patients had been in the direction of observable symptoms and tissue changes rather than in psychodynamic considerations. Kraepelinian classifications came into very formal use. After a patient had been classified in terms of the characteristics of his disease—that is, whether he was suffering from manic-depressive insanity, dementia præcox, and so on—little further study of him was attempted, except to decide what type of custodial care he would require for the duration of his illness. This classificatory formula remained characteristic of psychiatry well into the present century. Meyer's determination to direct attention to the content or meaning of the patient's experience and functioning, and his emphasis upon collaboration between patient and physician, brought a live and human character to psychiatric study and treatment.

As we all know, with the 1900's were ushered in various new approaches to the study and understanding of human behavior; these are often referred to as "the new psycholo-

[1] *Educating for Adjustment*, by Harry N. Rivlin. New York: D. Appleton-Century Company, 1936.

gies.'' Emphases in most of these have been upon genetic aspects, upon early developmental influences and certain dynamic relationships. As is usually the case with any widespread movement, the pioneers who blazed new trails were many, and to no one man alone could one justly give credit for the shift from the earlier static approach to the dynamic psychology and psychiatry of the present day. Freud gave his training to a limited number of workers, while his special concepts were perhaps most widely spread because of their special appeal or challenge and novelty. Meyer remained closer to everyday experience and means of treatment. Some look upon Bleuler in Europe and Adolf Meyer in America as the two outstanding *transition* figures in this shift from the old to a new psychiatry. Both are men of evolutionary rather than revolutionary type. While stepping out toward the new, they did not completely repudiate the old or accept new doctrines uncritically.

Nevertheless, the impact of Adolf Meyer upon American psychiatry was a resounding one. It was not to be expected that such an all-inclusive viewpoint as his would fit into the existing ''frame of reference'' of the medical profession, any more than it would have into the organized religious field had young Meyer elected that as his profession. From the outset, he was destined to be a pioneer in whatever professional field of activity he might choose. In the impact of such a creative personality upon almost any environment, old assumptions are challenged, accepted boundaries are pushed out to encompass new and greater perspectives. Such individuals are inevitably disturbing to those whose vision has been adapted to more limited horizons and whose activities have been confined to nicely restricted fields.

Understanding and appreciation of Adolf Meyer as this type of personality was expressed by his colleague, Dr. E. E. Southard, in an address made at the Seventy-fifth Anniversary Meeting of the American Medico-Psychological Association a quarter of a century ago. Reviewing the development of psychiatry for the preceding century, in speaking of the third quarter of that century, Southard said:

> ''Perspective interferes overmuch with our estimate of a typical personality for the third quarter-century. I myself believe that no greater

> power to change our minds about the problems of psychiatry has been at work in the interior of the psychiatric profession in America than the personality of Adolf Meyer. If he will pardon me the phrase, I shall designate him as a ferment, an enzyme, a catalyzer[1]—I don't know that we could abide two of him. But in our present status, we must be glad there was one of him. No American theoroist in psychiatry of these and the immediately succeeding decades but is compelled either to agree or else—a thing of equal importance—most powerfully to disagree with him. And who shall say that anybody is abler to get truth and reality out of disagreement and error than psychiatrists?''

Thus we see that psychobiology precipitated quite a shift in the accepted viewpoint of psychiatry back in 1897, when Dr. Meyer first promulgated it. Yet to-day, when one quotes the description of the child-guidance approach to the study of personality, written by an outstanding young psychiatrist, no one would find it startling. He says:

> ''The child-guidance approach to the study of personality is a study of the total behavior of the child, its development, and its relation to a many-sided background. Personality studies, from the child-guidance point of view, are attempts to learn how the child under investigation differs from other children, and the causes for these differences. It is perhaps the study of these individual variations and the interpretation given to their significance—always in terms of the setting in which they arise—that give this type of approach its differentiating stamp. . . . The underlying methodology of the child-guidance approach . . . is essentially the method of physical science, applied, with the necessary limitations, to social science. Arthur Jones, five years of age, is referred to the child-guidance clinic because of restlessness, disobedience, and temper tantrums. Before any hypotheses can be set up to explain this phenomenon, the facts of the case must be assembled and studied. This fact-finding process is called 'getting the history.' ''[2]

Contributions to Child Guidance.—Child guidance as an organized movement received its start and support from donors and leaders of the Commonwealth Fund, as a development differing in many ways from adult psychiatry. It is obvious, however, that the *child-guidance approach* described above is built squarely upon *psychobiological* foundations such as Adolf Meyer began laying in American psychiatry a half-century ago.

[1] Webster defines an *enzyme* as a complex organic substance capable of transforming by catalytic action some other compound. A *catalyzer* is a substance that accelerates reactions in other substances while itself remaining apparently unchanged.

[2] From *Approaches to Personality*, by Gardner Murphy and Friedrich Jensen. (New York: Coward-McCann Company, 1932.) The quotation is from Chapter VII, a supplement by the late Dr. John Levy.

Of course, many others have also poured their life energies and creative contributions into the psychiatry from which the child-guidance approach has arisen. In addition, side by side with the development in psychiatry, comparable progress in other fields made possible essential contributions that psychiatry could not furnish. The growth of the testing movement in psychology, with its objective, quantitative methods; the development of pediatrics as a special branch of medicine; the growth of endocrinology; the rapid development of scientific interest in the area known as child development; the emergence of case-work and psychiatric social service in the larger field of social work—these are some outstanding contributions that should be mentioned. From the field of education itself came such contributions as the nursery-school movement and that whole new, vital concept of the function of the school that John Dewey ushered in almost a half-century ago.

Progress, as Adolf Meyer has repeatedly pointed out during his long career, comes through *coöperative* efforts. "I live," he says, "by the principle that what we have in common is beyond doubt very much more essential and important than the things on which we differ, and through which we differ."

Earlier in this article it was pointed out that in addition to the general psychobiological approach, Adolf Meyer has contributed some specific methods and technics that have been directly carried over into our present child-guidance procedures. Outstanding among these is the *case history* or *life record* of the patient. He found in the early days of his work that physicians had, on the whole, but little confidence in the life record as a scientific fact. But his firm insistence that no patient be treated except against the background of his life history eventually won an accepted place for this essential instrument in the whole psychiatric field.

In one sense, both occupational therapy and psychiatric social work had their origins in Dr. Meyer's work, because it was *Mrs.* Adolf Meyer, the inspiring helpmate in his long career, who really initiated these supplementary forms of treatment through her activities in helping her husband with his patients and their families and nurses.

From the beginning, Dr. Meyer's work extended beyond the confines of the institution for the mentally ill. Out of a cloistered existence in mental hospitals, he brought psychiatry into homes, schools, and the community, before the child-guidance movement started. A definite characteristic of his work is to approach the abnormal *through* the normal. This urge to know the normal, to see the human organism always in its natural setting in the world, led Adolf Meyer early into an active interest in the homes, the schools, the businesses, the professions, and the communities from which his patients came and to which they should return. Always he has stressed the fact that it is just as important that society provide types of social organization and institutions to which human beings can make satisfying life adjustments as that the individual be able to adjust himself to the social organization in which he finds himself.

Before we close, let us consider briefly Dr. Meyer's early and lasting interest in childhood and in the training and education of children. Every modern "school" of psychology or psychiatry has recognized and emphasized the importance of the early years in the development of human personality. It was to be expected that as keen and alert a young psychiatrist as Adolf Meyer would soon turn his attention to childhood, once he got to working with the mental problems of adults.

He came to the United States in 1892. As early as 1895 we find him publishing, in the *Transactions of the Illinois Society for Child-Study,* an article on "Mental Abnormalities in Children During Primary Education,"[1] followed shortly by a *"schedule"* for the study of mental abnormalities in children, in the handbook of the new society.[2] In the 1903 *Proceedings of the National Education Association,* we find an article by him on "Arrest of Development in Adolescence,"[3] and in 1908 he published *What Do Histories of Cases of Insanity Teach Us Concerning Preventive Mental Hygiene During the Years of School Life?*[4] This was shortly after he had helped Clifford Beers to publish his book, *A Mind*

[1] *Transactions of the Illinois Society for Child-Study,* 1895. pp. 48–58.
[2] *Handbook, Illinois Society for Child-Study,* 1895. pp. 53-57.
[3] *Proceedings of the National Education Association,* 1903. pp. 813-15.
[4] *Psychological Clinic,* Vol. 2, pp. 89–101, 1908–1909.

That Found Itself, and had assisted Beers in launching The National Committee for Mental Hygiene, for which Dr. Meyer devised the name.

It was in 1906 and 1910 that he published his challenging papers, *The Fundamental Conceptions of Dementia-Præcox.*[1] and *The Dynamic Interpretation of Dementia-Præcox.*[2] In these Meyer urged recognition of the psychogenic factors in this disease and stressed the need for a dynamic conception of dementia præcox, with interpretations of the disorder based on psychological principles. This was a non-fatalistic position directing attention to the possibilities of preventive efforts. Inevitably, it emphasized the significance of early habit formations and the importance of seeing that in the development of a child's personality normal, wholesome reactions to life situations are not crowded out by reactions of an inferior type which may lead to progressive deterioration.

Other articles by Meyer on eugenics in relation to mental health and disease were directly related to the welfare of children. His outstanding published contribution to the education of children is his *Mental and Moral Health in a Constructive School Program,* one section of a book entitled, *Suggestions of Modern Science Concerning Education.*[3] The book comprises a series of talks given for the Chicago Woman's Club under the auspices of the Joint Committee on Education, with Mrs. Ethel S. Dummer as chairman.

Among early publications of the Progressive Education Association were two very important ones by Adolf Meyer—*Normal and Abnormal Repression,*[4] and *Freedom and Discipline.*[5] An article on "What Can the Psychiatrist Contribute to Character Education?" appeared in the *Journal of Religious Education.*[6] Two publications on the meaning

[1] *British Medical Journal,* Vol. 2, pp. 757–60, September, 1906.

[2] *American Journal of Psychology,* Vol. 21, pp. 385–403, July, 1910.

[3] *Suggestions of Modern Science Concerning Education,* by Herbert S. Jennings, John B. Watson, Adolf Meyer and William I. Thomas. New York: The Macmillan Company, 1917.

[4] Bulletin No. 13, Progressive Education Association, September, 1922.

[5] *Progressive Education,* Vol. 5, pp. 205–10, July–September, 1928.

[6] Vol. 25, pp. 414–21, 1930.

of maturity appeared in the early nineteen thirties.[1] An address (privately printed) at the Centenary of the Bloomingdale Hospital in 1923 summarized the entire philosophy of Dr. Meyer's conceptions. A paper on "Spontaneity" was presented at the Illinois Conference on Public Welfare in 1933.[2] Both of these papers have important implications for child guidance.

Space prevents discussion of the importance that Adolf Meyer attached to the nature of each child's school experiences. In the history of his own professional work, one event speaks for itself. The new psychiatric clinic at Johns Hopkins was opened in 1913. In 1914—the very next year—a member of Dr. Meyer's staff began a project in *a public school* of Baltimore.[3] Dr. Meyer never lost his interest in that project. Nearly twenty years later another member of his staff followed up men and women who had been studied as children in 1914, and published a report of their later life adjustments.[4]

Before closing, one final point about the psychobiological approach to the study of human behavior should be made clear. We have said that it is "eclectic." It is not eclectic, however, in the sense that it merely picks out and utilizes, as it needs them, theories from various schools and related disciplines. It pays due respect to all facts and strives to interpret them in the light of the sum total of knowledge gained thereby. Some interpretation for which these facts give evidence may be a theory current in some specific "school" of psychology; that would not bar it from use in a psychobiological interpretation of the case. Both in psychobiology and in child guidance, work can be scientific in so far

[1] "Maturity" *(Child Study,* Vol. 7, pp. 225–27, May, 1930) and "The Meaning of Maturity," in *Our Children, A Handbook for Parents,* edited by Dorothy Canfield Fisher and Sidonie Gruenberg (New York: The Viking Press, 1932).

[2] In *A Contribution of Mental Hygiene to Education.* Chicago: Report of the Mental Hygiene Division of the Illinois Conference on Public Welfare, 1933. Reprinted in *Sociometry; A Journal of Interpersonal Relations,* Vol. 4, pp. 150–67, February, 1941.

[3] See "The Subnormal Child; A Survey of the School Population in the Locust Point District of Baltimore," by C. M. Campbell. MENTAL HYGIENE, Vol. 1, pp. 96-147, January, 1917.

[4] "The Subnormal Child—Seventeen Years After," by Ruth E. Fairbank, MENTAL HYGIENE, Vol. 17, pp. 177–208, April, 1933.

as it can be solidly based on established facts. But the body of verified knowledge of behavior is so incomplete that in practical work we must sometimes base our procedures on theories that are still only *hypotheses,* to fill in the gaps in our scientific knowledge.

Child guidance is, therefore, eclectic; it adopts facts and hypotheses from various fields of research; it combines methods from medicine, psychology, education, and social work, and is willing to submit the hypothesis of any "school" to the objective test of *facts.* For the freedom to do this, child guidance in the United States is deeply indebted to Adolf Meyer, the dean of American psychiatry.

PSYCHIATRY SPEAKS TO DEMOCRACY *

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I HAVE a large measure of satisfaction and pleasure in being accorded the first Menas Gregory Memorial Lectureship. The giving of this lecture is a labor of love. Menas Gregory was my friend. He was a skilled and forthright psychiatrist. No memorializing is needed to secure his place in the annals of psychiatry.

The background of my remarks is the important fact that psychiatry is now one of the social sciences. It has emerged from the cocoon stage of the scrutiny and treatment of individual patients and is trying its wings with increasing confidence over the terrain of social psychopathology. My concrete text is taken from military psychiatry, with which, here and in overseas theaters, I have lived the past two years.

Two sharply contrasting pictures are deeply etched upon my mind. One picture I have seen in many seriously wounded youngsters, notably those who have suffered amputations, in overseas hospitals, here at Mitchel Field, and, in fact, in every army and navy hospital facility to which battle casualties are brought by plane and ship. It is an unforgettable picture, painted with the shining pigments of faith, gallantry, and unbroken morale.

In this picture, too, belong many of the psychiatric battle and operational casualties, like true "combat fatigue," with its clinical expression of catastrophic nightmares, startle reactions, and torturing guilt feelings. Many of these men could not be broken until great hardships, deprivation, exhaustion, tropical diseases, and soul-searing emotional experiences were placed in the balances against them. They were as honorably wounded as if they had been struck down

* Delivered as the first Menas Gregory Memorial Lecture, at Bellevue Hospital, New York, April 27, 1945.

by the fire of the enemy. Often, after the surface symptoms had been removed by food, sleep, and psychotherapy, indomitable courage and high morale were uncovered.

The contrasting picture is depressing. Against a clinical background of vague psychoneurotic symptoms, there are symptom areas of indefinite psychosomatic expressions—"tiredness," "headaches," "backache," and so on, and dark patches of unmilitary attitudes and psychopathic behavior. Courage and motivation are the nadir; morale is absent.

Military censorship forbids giving statistics. However, I know the numbers. I am not an alarmist, but the numbers are large enough so that these remarks are justifiably titled, *Psychiatry Speaks to Democracy.*

There is another contrast. Remembrance thrills at the sight of many thousands of young men in E.T.O., energetically and enthusiastically training for "D" day and impatiently awaiting its dawning. Then, since psychiatrists dare not forget it, there is the sad reflection upon many other thousands of young men rejected at induction or soon after—a large group in which oddly assorted neuropsychiatric symptoms only poorly camouflaged immature lack of motivation. An even more unpalatable truth, of which psychiatry and democracy must take thoughtful cognizance, is that almost 500,000 young men—enough men to man forty-one combat divisions—attempted to evade enrollment into military service, not hesitating to resort to any device, however shameful, even to the wearing of female clothing. It should be emphasized that these men did not claim to be conscientious objectors. They would not take even that risk of induction.

Conflict and Sickness.—Fortunately, it is not necessary to becloud the issue by attempting to answer the query: Which of these classes and which men in these classes are sick? They are all sick, the noble and the base alike—those psychiatric battle casualties who served splendidly and broke only after a load of somatic strain and emotional stress beyond the limits of average human endurance had been placed upon them; those who made a feeble attempt at service, but a short time after induction—a few months or even days—retreated under a cloak of vague neurotic symptoms;

those who failed to clear the induction hurdle because they were weighted by psychoneurotic and psychopathic impediments, often directly traceable to deficits in motivation. Those, too, were sick who did not make even a gesture of service—the draft "dodgers."

Not only are all these men sick, but the symptoms of their sickness represent the pathological resolution of an emotional conflict common to all—that of self-preservation versus "soldierly ideals." Briefly stated, the conflict is an unconscious struggle between the numerous behavior demands of our most ancient biological endowment, self-preservation—so dominant and insistent that it operates automatically in attempting to remove us from the path of danger to life and even strives to protect us from trivial discomforts—and, strongly opposing this, a constellation of behavior patterns, first anticipated and later acquired and strengthened in military service by regimentation, training, and discipline.

These instilled behavior concepts are numerous and complex. They include such realistic elements as the fear of being shot for cowardice, mounting through various higher levels and sometimes reaching such idealistic summits as the desire to fight for and, if necessary, die for the preservation of human democracy. If in our everyday living there is a constant struggle between self-preservative demands and threats to life and even to the lessening of physical comfort and ease, it is scarcely surprising that in war, at once in prospect and soon in actuality, the lance of self-preservation should be tilted, concretely and dramatically, against the lance of the expectations and demands of soldierly conduct.

It is true that the pattern of the underlying emotional conflict that may eventuate in neuropsychiatric disabilities has the same markings in those men who did not break until the somatic-emotional impact was severe enough and long enough continued to smash through very high thresholds as it has in those who have never been outside the continental limits of the United States and in whom the symptoms appeared within a few months of induction. Incidentally, this latter group comprised four-fifths of the case load early in the war.

There is, however, a vast difference between the two

groups as to the way in which the conflict is handled. In one, the available motivation and determination displayed—in other words, the amount of effort expended to control and inhibit behavior dictated by self-preservative demands—is at a very high level; in the other, it is practically at the vanishing point. On the one hand, there are those epics of human behavior under physical and psychological stress now so common that it is almost trite to recount them: exhausted marines in jungles infested by disease and the ghostly, taunting voices of the enemy; men at sea clinging to life rafts, strafed by the enemy's fire, witnessing their fellows go under; men in submarines shaken by the concussion of a depth charge, knowing that the next explosion might carry death to them; men in bombers with their best friends shot dead beside them; aviators down, injured and alone, in enemy territory with every hand against them; paratroopers hiding out behind enemy lines; men in "flat-tops," subjected to the suicidal, but destructive dive-bombing of the foe; the slogging, fighting, weary march of the infantry, through rain, snow, and mud, day in and day out; the long, monotonously boresome, but withal dangerous operations in ship convoy and plane; the men who wrote in characters of suffering and blood the glorious epic of the saving of the flat-top Franklin; the death marchers of Bataan. Small wonder that in some of these men, the resistance threshold is finally breached and psychoneurotic symptoms appear.

On the other hand, consider the reaction of many young men—far too many—in training and boot camps, a few weeks or months after induction. True enough, they are separated from their homes, but usually they are within writing, telephoning, and even visiting distances. Likewise true, the beds are apt to be less comfortable and the food less attractively served than at home. It is necessary to get up quite early in the morning and sometimes it is cold. The sergeant or the petty officer may be "tough." Some of their fellow soldiers may be rough and boisterous, given to "kidding" and playing practical jokes. There is considerable monotonous drilling and certain unpleasant duty details, such as fatiguing maneuvers—and field rations. There is much preparation and conditioning for battle, and the atmosphere may be heavily charged with anticipated dangers.

Such conditions seemingly are often—far too often—sufficient to break through the low resistance thresholds of many thousands of young Americans, erasing the last vestige of the motivation to serve, leveling the last barrier against the release of protective behavior activated by self-preservation, and setting into motion those mental mechanisms which eventuate in certain ill-defined psychoneurotic symptoms.

It is not difficult to find reasons for the breakdowns in the first group. Overwhelming precipitating factors may be found readily and frequently enough in the conditions of modern war on land, sea, and in the air—tremendous physical hazards and strains and devastating emotional experiences.

Neither, in my opinion, is it too difficult to find reasons, even basic ones, in the second group. In many it is merely necessary to retrace their lives for a few years beyond a decade of their current ages. Then, often, one may uncover certain grave deficits in early childhood training to which the current neuropsychiatric disabilities are reducible.

Now I am on dangerous terrain, because in the interest of democratic strivings I am about to indict a certain considerable number of American mothers, part of a time-honored and revered national institution and popularly and collectively known as "Mom." Among other things, it is the most powerful vote-getting lobby in American political life.

Without any thought of turning away the wrath I may incur, I should like to record that obviously there are more sensible, straight-thinking, psychologically "good" than confused, selfish, and psychologically "bad" mothers. Had it been otherwise, instead of beginning to glimpse military victory, we might now be facing the prospect of defeat.

The Mother Dilemma.—Every woman who bears and rears children is confronted by a dilemma. It is an age-old dilemma, which has become alarming in its proportions and dangers only in modern civilization and cultures, perhaps particularly in the United States.

The future social behavior of the child has its origin in and is patterned by the conflicting emotions arising from the parent-child relationship. For the child, the mother is not only the source of pleasure and the great protectress, but also the ruthless thwarter and frustrater. So the dilemma of the mother is likewise the dilemma of the child. In this

delicate ambivalent interaction between clinging and rejecting, there is acquired an innate capacity to meet successfully the give and take of mature individual and social life—or else this capacity is not developed and subsequently there is failure to adjust to self and to society. If the number of maternal parents who do not promote such adjustment, but prevent it, continues unchecked and increases, then our democracy-seeking will be impaled upon the child-possessive-love horn of the mother's dilemma. For democracy cannot be a matter only of taking. Unless there is an equal measure of giving, then that democracy is doomed to perish.

The Absorbing "Mom".—In his *Generation of Vipers,* Philip Wylie expresses his troubled concern about the situation. He tends, however, to describe "mom" in too vindictive personal terms. Actually "mom" may be beautiful or uncomely; dull or intellectual, though certainly not intelligent; rude or gracious. Her danger often is neatly camouflaged by a nice social exterior, perhaps successfully concealing her one deadly, all-absorbing purpose in life—the emotional satisfaction, almost repletion, that she derives from keeping her children paddling about feebly in a kind of psychological amniotic fluid instead of letting them swim away from her with the bold and decisive strokes of emotional maturity.

We have certain functions in common with animals and have not disdained to bring some of them into our civilization without overmuch modification. In some reactions, we are still close to the primitive. Perhaps it is unfortunate that too often we have discarded so completely the animal maternal function of teaching the young, and helping them from the very beginning to fend for themselves.

The mothers of men and women—men and women capable of facing life maturely, responsive and responsible social human animals, are not so apt to be the traditional "mom" type. More likely, the traditional "mom" is sweet, doting, self-sacrificing (?). The obverse of this cast, however, is not too uncommon—the stern, capable, self-contained, domineering type. Both these "moms" are busily engaged in finding in their children ego satisfactions for life's thwartings and frustrations, neither appreciating nor understanding the havoc they will leave in their wakes.

Almost always these women fit snugly and whole-heartedly into the social order as it has evolved in our matriarchy. Social acceptance increases their myopia for the real obligations of parenthood. The community applauds and admiringly and fondly smiles upon them. There is no urge, therefore, for them to examine their records as mothers. On the surface, they are accorded an overflowing meed of praise and even adulation for devoting their lives to their children. Hidden from view is the hard and tragic fact that in return—either directly or, even more destructively, indirectly—they exact as payment the emotional lives of their children. Usually they are paid in full.

It must not be forgotten that the "moms" are the products of the deficits in their own childhood relationships to their parents—deficits strongly favored by the social system in which we live. This system has many facets that reflect harmfully upon the child. An obvious one is an excessive amount of preoccupation with business and certain male social pursuits and sports by the male parent which hamper the mutual emotional progress of husband and wife, so significant for influencing favorably the maturing process in children. Not infrequently, thwarted and frustrated wives find compensation in the emotional absorption of their children.

Silver Cords.—Silver cords come in varying lengths. Sometimes they are very short, as in the case of "moms" who proudly, but somewhat naïvely, boast that their sixteen-to-seventeen-year-old children have never slept a single night outside their own homes. Much more often the cords are much longer, often quite long. Seemingly they allow for much freedom, so that it is surprising how quickly they can be drawn taut should the children wander near strange pastures. Whether the restraining cord is long or short, one thing is certain—it is very firmly affixed to its maternal source.

Seldom is the silver cord an obvious binding tie. It appears in many guises. A common one is seen in the time-consuming "trouble" some "moms" take in selecting for their children, well toward being grown up, their clothes and shoes, the cut of their hair, their companions, their sports and social attitudes and opinions. By "selecting" I do not mean wise

guidance, but dominance, sometimes hard and arbitrary, more often soft, persuasive, and somewhat devious.

There is a "mom" who will occasionally plaintively admit that she is "worn out," adding at once, however, "But what of that?" She finds her happiness in doing for her children from dawn until late at night. The house belongs to them. It must be "just so"—the meals on the minute and exactly right. There are no buttons missing from the children's garments in this orderly home. The service is almost continuous. Anything the children need or want—"mom" will be glad to get it or to do it for them.

The converse is the weak and frail little woman who has given her health and strength in the bearing of her children. Now at least one of them will find happiness in taking care of her—never leaving her side.

Sometimes the silver cord may softly knit together the family circle, in complete "harmony" and "happiness." Blessedly, arguments are checked and the hasty word is stilled in its utterance by the Pollyanna "mom"—"We love each other too much to quarrel." It is all very beautiful and very artificial, like a wax flower contrived by a skilled craftsman. It is *too* artificial. The home is *too* much of a sanctuary from the rough contest of everyday living. It is quite likely that one or more of the brood will remain in or return to this happy home, failing to find a comparable peaceful haven in the outside world.

There is the "mom" who—no doubt motivated by sincere, but sentimentally immature considerations—deftly and unerringly inserts herself as a protective barrier between the children—or, more often, between one child and justly merited censure from the father or the other children. The unfortunate victim of such solicitude is doomed to find out that the conditions of adult life swiftly nullify the emotional bond of protective security from deserved blame given in childhood.

There is a home that on the surface is a fairway for learning the strokes of decision and self-determination. The children decide everything for themselves—what they will do and what they will not do. I know of a number of such homes, in which this ultra-modern code is subscribed to as a

wise mental hygiene of childhood. Its actual source, however, is in compensation for an unhappy childhood in an environment of immediate and unexplained obedience to the commandments of a Jehovah-like father or mother. Unfortunately, giving children complete freedom, without guidance, control, or responsibility, is scarcely satisfactory. Such freedom is particularly unsatisfactory if it represents parental compensation for early-determined emotional immaturity due to rigid subjection to parents. The children are left as immature as were their parents. They are just as ill prepared to live in an adult world in which there must be a great deal of give as well as take.

I have described only a few of the many situations created by the "mom" who cannot or will not sever the emotional cord that once necessarily and constructively bound her children to her. All and many more things than those cited may and *should* be found in the mature mother, who sends forth into the world emotionally and socially strong and erect men and women. Wise guidance in early life, whether it be in the matter of selection of clothing or of opinions; a reasonably orderly and comfortable home; care and support from children in sickness and old age; a certain amount of harmony in the family circle; quiet, diplomatic interposition against unfair and undue or oversevere criticism by the father or other children; considerable latitude in self-determination of thought and behavior—all these things are necessary and good.

The difference between the emotionally mature mother and the immature "mom" is in the relative amounts of these ingredients in the mixture of motherhood and the motivation, conscious or unconscious, that prompts their usage. The mature mother uses them sparingly and wisely. Her purpose is to produce a proper balance of give and take in her children, so that they may attain full-statured personal and social maturity, and lead constructive and happy lives. The immature and insatiable "mom" employs the ingredients lavishly and unwisely in order to bind her children to herself with emotional coils. These children are doomed to live lives of personal and social inadequacy and unhappiness.

It is difficult to estimate how much awareness the "moms"

have of their destructive attitudes toward their children. Sometimes it would seem that there is a response to adverse personal criticism by a verbal insulation of the silver cord by platitudinous admonitions about "growing up." Naturally, these are quite incapable of influencing favorably the process of emotional maturing. They are shadows without any substance in the behavior of the "moms" themselves.

Furthermore, criticism is occasional and insignificant compared to the popularity and social approval accorded the tribe of "moms." In some communities I have noted certain children in their middle teens who have sensible and emotionally mature mothers, attempting either by open disapproval or by the exertion of various indirect pressures, to force from their mothers the same kind of emotional oversolicitude that their playmates receive from doting or domineering "moms."

It is useless to blame the "moms" too severely, since not only is their immaturity the product of their own childhood experiences, but public opinion idealizes and idolizes them indiscriminately. When, as frequently happens, a child becomes antisocial or even criminal, public judgment rationalizes the issue. Almost never is the "mom"—or the system that produced her—tried in the Court of Public Opinion along with her delinquent or criminal son or daughter. The "mom" is profoundly pitied.

What is badly needed is education and the promotion of a deeper understanding, which, among other objectives, might eventually bring about a clearer and better discrimination between the most valuable assets a democratic nation can have—real, mature mothers—and their spurious counterparts—the "moms" who feebly imitate, but grossly distort, the psychological functions of true motherhood.

Without too much protest, perhaps not enough, American education has accepted many radical curricular changes because of the war. It would not be amiss if it added to the humanities real teaching concerning the functions of motherhood. If properly taught, such a course might inculcate into the personality the motivation to become a mother rather than a "mom," and conceivably, too, it might produce a healthy rebellion on the part of children against the tech-

niques of "moms." Such teaching could scarcely be begun too early in the schooling of children or continued too long.

There are hopeful stirrings in this direction—notably nursery schools and parent-teacher groups. However, expansion and sound psychiatric monitoring is needed for these groups.

"Mom" Surrogates.—Paradoxically, sometimes "pop" is "mom." In fact, "mom" has protean characteristics and may be observed in various rôles. Not only are there emotionally dependent male parents who block the attempts of mature wives to bring the children to full-grown emotional and social stature, but there is also a long line of "mom" surrogates—grandparents, uncles and aunts, friends, sometimes teachers, and even college professors. All these and many others, driven by the need of finding ego satisfactions for their own immaturity, may readily undergo metamorphoses into "moms."

Military Versus Social Motivation.—I mentioned that my text was taken from the alarmingly large number of young men in the training areas of the army, in navy boot camps, and at induction, who were not able to serve because of indefinite psychoneurotic and psychosomatic symptoms and phychopathic behavior. I think a considerable proportion of the number is due to the fact that these rejectees had "moms" instead of mothers. I have frequently heard the objection that lack of stomach or motivation for war, an unwillingness to kill other human beings, does not indicate an inadequacy of social responsiveness and responsibility. It is concluded, therefore, that those mothers who did not raise their boys to be soldiers, and who conditioned the early training of their sons so that in one way or another they avoided the danger of being fed into the maw of Mars, are far from being emotionally immature "moms." Indeed, it is asserted that socially, culturally, and spiritually, they are much in advance of ordinary mothers whose sons fight and win the battles of the war. If this were true, it would deserve very careful consideration. *It is not true.*

In the men I have in mind the low level of appreciation of social responsibility and motivation is not confined to military service. In fact, it is not selective at all, but gen-

eral. It may reveal itself in face of any demand for social service—fighting a forest fire, strengthening the flood banks of a river, shoveling the snow bottlenecking a highway. Even more emphatically, everyday living writes the record of emotional and social deficits in these personalities and is the true criterion. It is a record in which, in the balance of personal, family, community, and national life, "taking" far outweighs "giving," so-called "rights" and "privileges" to be obtained far outweigh duties and obligations to be met.

Of course, there are modifications and even exceptions. In a certain segment the lack of social responsiveness is largely confined to war. War provides a severe test, entailing separation from home and concrete danger to life. It is only fair to say that some "moms" almost succeed in being mothers. They have accomplished varying degrees of emotional and social maturing in their children and, for some of these youngsters, military life is the badly needed opportunity. In this group are those who do satisfactory jobs in the army, and there are a few who perform gloriously. There is another group who do respond to demands for social service, if these are not continued "too long." There are even some who pursue a Rip Van Winkle-ish existence, serving other needs eagerly, but neglecting the direct responsibilities they have acquired in life.

The Conscientious Objector.—The legitimate conscientious objector, his legitimacy attested by his sincerity and his willingness to serve in ways other than killing, is not necessarily short in emotional and social stature. If he is sincere, he is living out a conviction, which, perhaps impractical at this step of human affairs, is not *per se* immature. It is not at all impossible that some time in the future, when our civilizations and cultures have become more stabilized, the archaic code of killing one another in order to settle our differences will be abolished. Then the creed of the honest conscientious objector will have civilized and cultural sanctions.

Psychiatry Speaks to Democracy.—In World War I, the over-all ratio was one neuropsychiatric breakdown in each seven, including wounds and sickness. Exclusive of wounds, the proportion was 1:3. With selection at induction and during training somewhat—although not much—better in World

War II, it is astounding that military ineffectiveness due to neuropsychiatric conditions is certainly 25 per cent of the total—probably more.

Before reaching conclusions, certain factors pertaining to the unusual conditions of this global war should be counted among the premises. This war is being fought under geographical and climatic conditions that provide a much more severe test than did the conditions of World War I. Furthermore, a much larger segment of the action in the present conflict occurs in media both unphysiological and unpsychological—at oxygen-deprivation heights or far below sea level. Finally, engineering and chemical genius have vastly multiplied the lethal power and incidentally the emotionally devastating effect of the machines and instruments of war.

Nevertheless, it is extremely unlikely that these and other factors sufficiently explain the increase in military neuropsychiatric breakdowns within the short space of twenty-five years. For one thing, the much larger fraction of the total, probably four-fifths, occurs in young men who have not been subjected to the acid tests of the war, geographically or climatically, or to the hazard of life or the emotional disruption of personality. For another, the bulk of the problem consists of so-called psychoneuroses. Generally speaking, these would scarcely fulfill the clinical criteria of the psychoneuroses of civilian psychiatry. Unquestionably, too, the majority have their symptomatic source in weak and faltering motivation. One would not be far afield in thinking of these "psychoneuroses" as expressions of impaired and insufficient morale, a failure to develop even a minimal amount of social responsiveness and obligation during the formative childhood years. *Here precisely in the low level of morale is the social danger and the threat to the survival of our democracy.*

In the peace-time practice of psychiatry, we encountered not too infrequently individuals trapped by life because they lacked in their personalities even the beginnings of social morale, or else its stirrings, prompted by social expectations, were so vague that they were not comprehended. It was not difficult to retrace their social helplessness to a vacuum during their childhoods, produced by the ego-grasping immaturity of their "moms." Until we were forced to prepare

for war, however, we had no idea how common these situations were. In the huge test tube of military man power, the gigantic outlines of the problem have been clearly revealed.

That intangible, but at the same time very real, quantity called morale is an implacable force that shapes human events—whether it be in the life of one person or in the affairs of a nation—for weal or for woe. This is true alike in war or peace.

If morale in soldier and civilian is low during war, then there is danger of defeat. An unstinting flow of the machines and supplies of war is needed to strike at military objectives, but to take and hold those objectives, what is needed above all else is morale.

A political orator, no matter what he is talking about, may count on a resounding burst of applause if he states that the hand that rocks the cradle makes the morale of the nation. The applause would be somewhat less enthusiastic if he added a "but" to the effect that there are too many "moms" who are not really mothers, and that the kind of morale they are busily and selfishly making in their children is a national hazard rather than an asset. There would be no applause at all, and he would probably lose votes, if he dared to conclude that if the number of this type of "mom" continued to increase, then we might well face defeat should there be another war catastrophe.

In this war we have already paid a high price for the too large number of "mom"-made ineffectives. We will pay a still higher price in the years to come. The economic outlay will be the smallest and least significant part of that price, as the "takers" crowd the "givers" for the privileges and benefits guaranteed by the G.I. Bill of Rights and other legislation still to be enacted.

Even more in peace than in war, particularly in a nation that aspires to democratic ways of life, high morale is needed to move us toward our objectives—is, indeed, imperative for our survival. The existence of a truly democracy-seeking nation is imperiled not only by aggressive faults of commission, but even more seriously by sins of omission. Immature, selfish "moms" produce sons and daughters who usually are not capable of making more than an indifferent economic

return and almost always are quite incapable of more than a futile social gesture. They occupy the area of democracy as "squatters." Real and mature mothers produce men and women who till and cultivate the national soil—economically and socially. If the "moms" increase disproportionately at the expense of the mothers, then there is real danger that the non-productive "squatters" will dispossess the contributing and constructive citizens.

The intermediate, mutually held territory between "I and You" should be—in fact, must be—a land of fair "give and take," of reasonable concessions and of decent tolerances. While this area necessarily must have shifting boundaries, yet it is so significant that it is not too much to say that the survival or the death of our democracy-seeking nation will depend upon a clearer understanding and a more accurate delineation of the "I and You" relationships enclosed in this area.

Such clearer understanding, more accurate delineation, and, indeed, safeguarding of the personal and social essence of democracy can be accomplished only if the nation is furnished with a maximum supply of true mothers and if there is a steadily diminishing minority of "moms."

It is to be reiterated and reëmphasized that the danger of the "mom" is a surface fissure warning us of deeper defects, inadequacies, and insecurities in our social system.

THE INTERDEPENDENCE OF DEMOCRACY AND MENTAL HEALTH

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PSYCHIATRISTS must speak out!

We must address ourselves to those serious-minded citizens of our country who accept the *obligations* of citizenship as readily as they claim their *rights*. Ours is no special pleading for a special cause—unless an urgent appeal for attention to a particularly serious problem of our country can be so described.

What we must tell our fellow citizens is not debatable and is certainly not something that can be politely noted and then promptly forgotten. For ours must be a warning to the responsible adults of our country that they must part, once and for all, with certain infantile attitudes toward the problems of mental health. We must persist until public apathy is replaced by an aroused social consciousness and a determination to do something about it.

By June, 1944, out of the fourteen million men examined for induction into the armed forces, 4,250,000 had been rejected because of some medical disability. Of this group of rejectees, approximately 35 per cent were rejected because of neuropsychiatric reasons.

Almost as many of the medical discharges from the army have been for neuropsychiatric reasons as for all other causes combined, and this does not include the psychopaths and mental defectives who are discharged under a non-medical category.

Mental disorders discovered among troops in the army may be classed in the following categories: serious mental illness that may have existed prior to induction, but that somehow escaped detection at the time of the medical examination; mental illness that may have been latent or mild prior to induction and that was precipitated or accen-

tuated after induction; mental illness that did not exist prior to induction, but developed after the soldier entered the service.

What was the situation in which the newly arrived citizen-soldier found himself? Almost three years ago, we wrote:

> "Modern warfare is intense and amazingly fast. Static warfare has given way to ever-moving, dynamic combat. Dive-bombers, massive tank divisions, giant high-explosive bombs, the concentrated firing power of automatic weapons, the use of paratroopers and commandos—all call for men with stable nervous systems. It is quite correct to say that the soldier of to-day in the field of combat is being subjected to strain and pressure that has not been equaled or even approached in any previous war. The degree of efficient teamwork which modern mechanized warfare demands, and depends on, leaves no room for a weak link that will snap under pressure, with resultant tragedy to an entire unit."[1]

At the same time we also stated:

> "High morale springs from a full knowledge of the meaning and the significance of this war. It enables an individual or masses of individuals to carry on and preserve in their mission in spite of adverse conditions, disheartening developments, defeatist rumors, fatigue, hunger, and physical discomforts. It is a state of mind which can come to a soldier only when special pains are taken to instruct him in the fundamental issues at hand—to make him feel that he is an integral part of everything his nation is fighting for—to arouse in him a social consciousness the like of which he has never felt before. This most necessary condition can be achieved only through a systematic program of education. Men who are imbued with a zeal which springs from a full knowledge of what they are fighting for are less apt to experience emotional or other personality disorders as a result of actual warfare."[2]

We stressed that it was not enough to find the already existing neuropsychiatric misfit. We pointed out the urgent need for the development of a high degree of morale in order to serve as a bulwark against the development of serious mental disorders.[3]

Men came into the armed forces by the millions. The author had the privilege of personally interviewing thousands. Perhaps one of the most outstanding findings made quite early was the fact that so few of our soldiers seemed

[1] See "Neuropsychiatric Program for a Replacement Training Center," by L. S. Stilwell and Julius Schreiber. *War Medicine*, Vol. 3, pp. 20–29, January, 1943.

[2] *Ibid.*

[3] See "Morale Aspects of Military Mental Hygiene," by Julius Schreiber. *Diseases of the Nervous System*, Vol. 4, pp. 197-201, July, 1943.

anxious to get into the fight. As the author has pointed out elsewhere,[1] careful studies of these men, particularly the so-called "problem cases," did not reveal overt fear except in a relatively few instances. By far the outstanding finding was marked ignorance of the underlying issues of the war, often accompanied by outright resentment pointed in various directions other than against the common enemy. Troops brought with them all the doubts and suspicions and prejudices that they shared with their families and friends and neighbors while civilians. It was not at all unusual to hear that we had been "sucked in by that war monger!"; or that "imperialistic Britain had finally roped us in"; or that, as a matter of fact, we were going to war for "Communistic Russia," or "the Jews," or "Wall Street"—in short many, far too many, felt that they were being called upon to risk their lives for a cause that was not their own.

This lack of orientation to the realities of life and the history of the world forced many of our soldiers to pay a heavy tribute. Resentment, anger, and hatred were directed against the President, or the Congress, or the army, or the Allies, or racial, religious, and economic groups instead of being channelized against the enemy. Small wonder, then, that confusion, frustration, and anxiety took hold. Men who were not deeply convinced of the righteousness of our cause and of the need to destroy the enemy even at the risk of their own personal safety could not reasonably be expected to escape serious emotional disturbances, with the resultant psychosomatic conversions.

They had come ill-prepared to fight a life-and-death struggle for democracy because the very meaning of the word was lost for many. A disturbing number were extremely cynical and suspicious of any phraseology that suggested a serious understanding of the issues of the war.

American youth were being called upon to run the risk of smashed skulls and bayoneted abdomens—and they consciously or unconsciously asked, "Why?" Our society had

[1] See "Square Pegs in Fox Holes" (*Beacon*, The Bulletin of the Mental Hygiene Society of Northern California, Vol. 2, No. 3, September-October, 1943) and "Psychological Training and Orientation of Soldiers" (MENTAL HYGIENE, Vol. 28, pp. 537-54, October, 1944), both by Julius Schreiber.

failed to give them the answers. They *heard* democratic words, but *saw* undemocratic practices.

Negroes came to serve, but even though in uniform, they felt the hot, stinging shame of race hate and discrimination from some of our white fellow Americans in civilian clothes. "We don't serve Niggers here!" their benighted "white brothers" told them. And Negro soldiers who were training to defend "our" democracy turned and walked away with thirst unquenched.

"Why do you fight us?" Nazi prisoners of war asked their guards in prison camps. "You hate Niggers and so do we!" And the guards could only bite their lips and wonder.

"Damn Jews," "Damn Catholics," "Damn Protestants," "Damn Wops," "Damn Communists," "Damn Labor," "Damn Business," "Damn Niggers," "Damn Whites," "Damn Irish"—Damn everybody!

Nothing new for the men in the army. Didn't they hear it in their homes? Their factories? Their clubs? Their neighborhoods?

And so they came into the service with their damns and their hates. No ally, race, religion, or economic group escaped a slur or an attack. And yet these same hating soldiers were asked to destroy an enemy that promoted their very own hates! "Who? Me?" he might well have asked. But he didn't do so, out loud. Usually he kept it to himself and let his heart skip faster, his stomach churn, his back ache, and his bladder empty more frequently.

Intolerant people actually suffer because of their hate and prejudices. Their personalities inevitably warp; and their psychopathy, like many another disease, tends to spread. According to Levy:

> "Intolerant people are people who hate. Their degree of intolerance is a measure of their hate. When a person is characteristically intolerant, he belongs to the group of the psychologically hostile, whose features I shall attempt to describe. The most distinctive finding among the psychologically hostile is a stultification of the personality. In a well-known personality test such individuals, for whom hatred is so vital a function, are found to be characterized by a marked *narrowing* of the thought, feelings, and imagination. The generalization applies equally well to the haters who have repressed their hate and to those who express it directly, in words or action. . . .
>
> "The disseminator of intolerance, operating on the fertile soil of the

psychologically hostile, may initiate an epidemic of hate, as readily comprehensible as an epidemic of typhoid fever. The source of either epidemic, whether of typhoid or of hate, would be considered equally dangerous and criminal, if public understanding of mental health were at all effective."[1]

Said Everett R. Clinchy:

"Look back over the past one hundred years and you will discover that families and schools and churches apparently have ignored the need for education necessary to enable us to live in a country characterized by such cultural many-ness. We have had secret societies galore, like the Know-Nothing Movement, the American Protective Association, and the Ku Klux Klan. Parents and teachers of children have not solved the problem of intercultural relations because they have not definitely faced it. Prejudice, persecution, and hate hysterias have been common enough; but like other common facts of life, they have been taboo subjects."[2]

Yes, America had failed to "sell" democracy to its sons. True, we had our "civics" classes in school, but that is where the "civics" remained—in school! The homes, the streets, the workshops, the clubs, the neighborhoods had a peculiar brand of "civics" and all too often it began with the simple prefix: "Anti——!"

And whenever some conscientious citizens cried out against what they saw, they were, in the main ignored or were but passively approved from the sidelines. Sometimes, these enlightened citizens were treated to a variety of name-calling: "Crack-pot idealists!" "Communists!" "Nigger-lovers!" "Troublemakers!" "Fellow travelers!" "Screwball Y.M.C.A. sob sisters!" And what parents say growing children tend to echo! And echo they did!

The army took America's sons and trained them to kill America's enemies. It taught them how to use the weapons of destruction. It made them physically fit. It conditioned them to the noise and rush and fury of battle. It taught them discipline. And it tried to do one thing more—it tried to teach them *why* we had to go to war, *what* we were fighting *against, what* we were fighting *for;* it tried to instill in every man a sense of personal importance; and above all, it tried

[1] See "The Toll of Intolerance Upon the Intolerant," by David M. Levy, in *The Family in a World at War,* edited by S. M. Gruenberg. New York: Harper and Brothers, 1942. pp. 117-24.

[2] See "Unity in Diversity," by Everett R. Clinchy. *Ibid.,* pp. 125–29.

to develop personal faith in our way of life, our country, and its future.[1]

America's sons will soon return to civilian life. Is America ready for them? Are enlightened citizens ready to assume their responsibilities? In a democracy, civilians, not the military, say what the country is to do. This war revealed that the community had failed to make democracy and citizenship a highly personal and meaningful thing for our youth. The army tried to accomplish in a few months what society had failed to do in years. But the army had one advantage: The young men of our country were invited to run the risk of dying and we, at least, were ready to answer *why* the need for that risk.

Now our youth is returning home. What now? Have we learned one of the major lessons of the war? Have we learned that one cannot deny democratic life to people who are brought up in an atmosphere where talk of it is prevalent without inducing serious emotional problems, with all the resultant disturbances that follow? Have we learned that true *mental health is dependent upon democratic thought and practice?* Can psychiatrists, educators, civic leaders, church men, leaders of industry and labor, legislators—all of us—can we afford to sit back?

What About the Future?—There are at least three extremely vital tasks that call for special attention: (1) to enhance, extend, and improve the facilities and methods of research and training; (2) to increase the number of psychiatrists and to extend and improve psychiatric services; and (3) to study contemporary social practices and institutions in order to learn which enhance and which undermine the mental health of the country and to make whatever recommendations may be necessary.

It is the last point—the rôle of contemporary social institutions and practices in the development or the undermining of mental hygiene—that for the present concerns us most.

This is not a new field. Many studies have been made and innumerable opinions have been voiced. But before we

[1] See "Psychological Training and Orientation of Soldiers," by Julius Schreiber. *loc. cit.*

go any further, let us remind ourselves of the meaning of the term, *"mental hygiene."*

While the term has had various meanings during the past hundred years, the definition given by Rosanoff is undoubtedly one of the best:

> "Mental hygiene, the science and practice of the preservation of mental health. The broadest conception of mental hygiene envisages a threefold purpose: (a) the prevention of mental disorders; (b) such adjustments—physical, educational, vocational, economic, social, sexual, etc.—as would result in the fullest and happiest utilization of inborn endowments and capacities; and (c) the improvement and increase of inborn endowments and capacities through eugenics."[1]

Let us see what has been said concerning the relationship between certain social institutions and practices and mental health. Rosanoff expressed his views on this subject in no uncertain terms:

> "The importance of social and economic factors in the etiology of mental disorders has been repeatedly emphasized. . . . They play a part—for better or for worse—in everything: Prostitution, syphilis, sexual maladjustments, postponement of marriage, cerebral birth trauma, alcoholism, drug addictions, avitaminoses, manic-depressive and schizophrenic psychoses, industrial accidents and poisonings, suicide, gambling, delinquency, crime—everything! . . . What a clearance shall be achieved when, in a more rationally organized society, every able-bodied person shall have a full opportunity to engage in constructive work with resulting security for himself and his natural dependents, we may only surmise; but we have every reason for saying that until such a time arrives it will be quite impossible to put into effect a complete mental-hygiene program."[2]

Rosanoff is not alone in his views. According to the anthropologist, Ruth Benedict:

> "Psychiatrists and research workers have given little serious attention to social factors. . . . The necessary task is to identify cultural institutions which correlate, at any stage of human development, with mental health and ill-health."[3]

From the thousands of social institutions and practices, let us select, for purposes of discussion, just two—economic insecurity and racial and religious intolerance.

[1] See *Manual of Psychiatry and Mental Hygiene*, by Aaron J. Rosanoff. Seventh edition. New York: John Wiley and Sons, 1938.

[2] *Ibid.*

[3] See "Some Coöperative Data on Culture and Personality With Reference to the Promotion of Mental Health," by Ruth Benedict, in *Mental Health* (Publication of the American Association for the Advancement of Science, No. 9), edited by F. R. Moulton and P. O. Komora. Lancaster, Pennsylvania: The Science Press, 1939. pp. 245–49.

The coexistence of economic insecurity and racial and religious intolerance along with mental illness does not necessarily, of course, establish a causal relationship. Even though statistical studies show a high incidence of mental illness in those who are in the lower income brackets, this does not necessarily prove that mental illness follows economic insecurity. First, one would have to show that economic insecurity undermines mental health.

When it comes to racial and religious intolerance, the task is simpler. Here it is not difficult to prove that aggressions against individuals because of race or religion are not brought on because the victims of such aggressions are mentally ill. The question is finally this: Do anti-minority attitudes and economic insecurity result in emotional disturbances sufficiently severe to undermine the mental health of the victims of such situations? That emotional disturbances can play havoc with an individual is not open to debate; the entire discipline of psychosomatics is based upon this premise. As Dunbar puts it:

> "Programs for preserving even mental health cannot be constructed in terms of mental disease alone. Emotional disturbances are often the precursors of mental illness and so must be considered in any preventive program, but they may lead to physical illness as well."[1]

The crux of the matter is simply this: If certain social institutions and practices induce serious emotional disturbances, they must be considered as likely causal factors in the undermining of mental health. To the question, "If they operate in the production of mental illness in some individuals, why do not these same institutions and practices produce mental illness in others?" there is this answer: "It is sufficient to recognize that serious emotional disturbances derive from certain institutions and practices. As for the subsequent development or absence of mental illness, this will depend upon other factors, not the least among them being the conditioning and the capacity of the individual to fight back against these institutions and practices or to sublimate his conflicts."

What rôle, then, may *economic factors* play upon mental health?

[1] See "The Bearing of Emotional Factors on Social Health Programs Dealing With Economic Disability," by H. F. Dunbar. *Ibid.*, pp. 199-210.

Malzberg appears to be somewhat uncertain. While recognizing that rates of mental disease are relatively high in the lower economic groups, he cautions, "We must yet recognize that we are concerned with a mingling of diverse factors, some economic, some social, and others of a personal and constitutional nature."[1]

Falk and Hirsch are much more positive:

> "To the extent that such measures [social security] do provide assurance of income, they serve as preventive measures by securing society to some degree against the development of mental deviation arising out of economic fears and worries."[2]

Zubin sees the problem as a "vicious circle" which "must be broken if mental health is to be preserved." He points out that "economic status is a factor in mental disorders, and mental disorders in turn affect economic welfare."[3]

Sapir expressed himself quite bluntly:

> "For all practical purposes, a too low income is at least as significant a datum in the causation of mental ill-health as a buried Œdipus complex or sex trauma. Why should not the psychiatrist be frank enough to call attention to the great evils of unemployment or lack of economic security? His recognized concern for the well-being of the individual gives him every right to be heard, where ordinary opinion or common sense is often dismissed as governed by sentimental prejudices."[4]

Perhaps the entire story of the rôle of economic insecurity in the production of mental ill health is not entirely known. But enough is known to make one heartily concur with Sapir when he called upon psychiatrists to "be frank enough to call attention to the great evils of unemployment or lack of economic security."

The intimate connection between the problem of the *threat of economic security* and the problem of *racial and religious intolerance* is sharply seen in the aggressive attitudes on the

[1] See "The Influence of Economic Factors on Mental Health," by Benjamin Malzberg. *Ibid.*, pp. 185-91.

[2] See "Social Security Measures as Factors in Mental Health Programs," by I. S. Falk and N. O. M. Hirsch. *Ibid.*, pp. 192-98.

[3] See "The Economic Aspects of Mental Disease" (summary and critique), by Joseph Zubin. *Ibid.*, pp. 211-18.

[4] See "Psychiatric and Cultural Pitfalls in the Business of Getting a Living," by Edward Sapir. *Ibid.*, pp. 237-44.

part of the native populations toward the foreign-born. This problem is well presented by Reichard:

> "The effect on individual and community mental hygiene of the changes initiated by immigration are not susceptible of statistical analysis, and can only be conjectured. However, we feel that there is an inverse relationship between the degree of security of a group and the incidence of certain types of mental disease, particularly the neuroses and 'functional' psychoses. Anything that decreases security probably increases the incidence of those personality maladjustments . . ."[1]

Advice well worth following is given by Myerson:

> "It is important for the country into which the immigrant comes to keep certain facts in mind; namely, the more hostility which is felt and expressed, the more the new individuals tend to become segregated and, so to speak, to remain alien. The more burdens put upon them by poor housing, poor food, and lesser economic opportunity, the more criminals and the more maladjusted people they will contribute to the population, the more they become social problems. Here is certainly a case where the wisdom of toleration becomes of the greatest importance. Americanization of an immigrant group includes not only the teaching of American customs, history, and habits, but it includes the admission emotionally of the new individuals to the American families, since cordiality and opportunity tend to break down alien peculiarities and more readily assimilate them into the mass of the population."[2]

The problems of the foreign-born quite naturally suggest the problems experienced by all minority groups. The battles and the struggles of members of such groups to win social acceptance, to find a niche in the community for themselves, is at times a tragic record of the failure to put our democratic beliefs into practice. Inane and unscientific arguments to the effect that some of "these people are biologically inferior" are not worthy of reply. No psychiatrist, except those in Nazi Germany and her allied states, would ever seriously make such a statement. The myth of "racial purity," and the fallacy that man's social behavior is primarily biologically rather than culturally determined, needs no reply here. The wise observation, "Nature says what may happen, but nurture says what will happen," is still valid. The opportunities that are afforded an individual to

[1] "Immigration and the Mental Health of Communities," by J. D. Reichard. *Ibid.*, pp. 115-19.

[2] See "Sources of Mental Disease" (summary and critique), by A. Meyerson. *Ibid.*, pp. 120-33.

"blossom out and flower" are of much greater significance than many of the genes that may be tucked away in some of his chromosomes. A beneficent social environment will protect many an individual from the development of a mental disorder that may be potentially present because of "tainted" heredity; while, on the other hand, a social environment that induces constant tension, anxiety, and frustration will not only evoke the pathological contributions of heredity, if they are present, but will even create mental ill health in those individuals in whom hereditary factors are out of the question.

It would be gratuitous to point out that the new-born babe is not born with a "Damn Jew" or "Damn Nigger!" or "Damn Catholic!" or "Damn this-or-that" complex engraved in his cortex. We all know the story. Before our children are old enough to go to school and "prepare themselves for the business of living," attitudes and seemingly final conclusions have already been made for them by parents and relatives and neighbors. Says Rosanoff:

> "Thus it is that, for the most part in the pre-school period, it is determined in a given case whether he shall be a Protestant or a Catholic, a Republican or a Democrat, a reactionary or a progressive; the preconceptions, prejudices, bigotries, superstitions, even enmities and hatreds, of the grown-ups are woven into his personality more or less permanently."[1]

It is admitted that the contributions that biology and social environment make toward the over-all equipment that our youth need in order to assume their rôles as responsible citizens in the community cannot be controlled entirely by parents or society at large. To the extent, however, that factors that are incompatible with mental hygiene can be controlled and yet are nevertheless neglected—to that extent are we derelict in our obligations to our children and to our country.

Young people who go out to meet life with warped or inadequate or outmoded social attitudes and points of view will inevitably come into conflict. Young people who are either victims of or participants in a discrepancy between what is preached and what is practiced cannot escape the

[1] *Op. cit.*

emotional penalties that inevitably derive from such conditions. As the author has previously pointed out, many of the "psychiatric problems" found among the soldiers were the result of emotional disturbances brought about by the conflicts resulting from the discrepancies between the soldiers' information, attitudes, and general conditioning, on the one hand, and the things he was asked to believe in and act upon, on the other hand.

Said Vice Admiral Ross T. McIntire, Surgeon General, U. S. Navy:

> "In my opinion, thorough preparation must be made in any plan of physical training that will take in proper mental training to avoid the neuropsychiatric symptoms that we see developing in our young Americans."[1]

And Colonel William C. Menninger, Director, Neuropsychiatric Division, U. S. Army, makes the statement:

> "This finding [the high incidence of psychoneurosis among men rejected by Selective Service] does have an important sociological significance which should not be ignored, and has ramifications into our democratic way of living, our determination to be individualists, and our resentment of authority. It concerns our family life and educational system."[2]

The author is aware of the fact that he is subjecting the reader to a lengthy series of quotations. He does so deliberately. He refuses to gamble on a possible dismissal of his thesis by a casual reader who may remark, "That's just one man's point of view!" The importance and significance of this problem for our country can no longer be treated so lightly. This is *not* one man's point of view—it is shared and has been expressed by responsible workers in all fields of the medical and social sciences. The facts have been available for all to hear and to see—and for quite some time. What is needed is to *do something about it.*

One cannot say that a man has mental health merely because he shows no evidence of a psychopathic personality or a neurosis or a psychosis. Mental health is much more. The late C. Macfie Campbell stated it very well:

[1] Testimony before the Senate Subcommittee on Wartime Health and Education, July 10, 1944.

[2] Testimony before the Senate Subcommittee in Wartime Health and Education, July 11, 1944.

> "Mental health is more than the absence of mental illness; it is the condition in which the individual attains a certain internal equilibrium and adequate self-expression, utilizes the fulness of his endowment, has a moderate feeling of well-being or joy, makes his contribution to the life of the community. Merely to rub along in a way which attracts the attention of nobody, and without any gross personal dissatisfaction is a poor standard of mental health."[1]

The entire story is well summarized by Frank:

> "The democratic aspirations of man cannot be achieved so long as individuals are warped, distorted, and mentally sick, since only sane, integrated personalities, who have learned to accept themselves, can exhibit the understanding and voluntary coöperation that are necessary to a democratic society. The children of to-day are the society of to-morrow; the personalities we are now fostering in the educational process of the home and school will dominate the social life of to-morrow. *Whatever fosters and promotes mental health will guard and advance democracy.*"[2]

The reverse of that statement is equally true: *Whatever fosters and promotes democracy will guard and advance mental health!* Therein lies the rub! Every one is for mental health—no question about it; every one wants to be mentally well, and out of the goodness of his heart he would just as soon see his fellow men also mentally well. As a matter of fact, as has already been pointed out, from a purely selfish point of view, it's economical for the taxpayer to see that a high level of mental health is maintained in the country.

When it is stated that the factors that advance mental health will also advance democracy, every one will applaud. When it is stated that the factors that advance democracy will also advance mental health, there will still be applause—until it is actualy insisted that the way to practice democracy is simply to practice it! And here we have some trouble.

Our democratic faith and principles have but two objectives—to insure and increase the *dignity* and *security* of the individual. These are dependent upon the four pillars of democracy—equality of men, rule by the people, civil liberties, and opportunity for economic security.

[1] See "Human Needs and Social Resources," by C. Macfie Campbell, in *Mental Health, op. cit.* pp. 457–70.

[2] See Summary of Discussion on "The Reorientation of Education to the Promotion of Mental Hygiene," by Lawrence K. Frank. *Ibid.*, pp. 284-85.

It is easy to say that one believes in democracy, but it is quite another thing actually to practice it. One need not elaborate here. A few moments reflection will recall the glaring discrepancy between professed faith and day-by-day action. Consider the violence done to the principle: All men are created equal! Consider the sense of betrayal experienced by large sections of our citizenry when we glibly say that the people rule! Consider the shame and the rage of those among us who do not share in what we proudly call our civil liberties! Consider the doubts and emotional tensions of millions and their readiness to listen to "isms" when the opportunity for economic security is present for them on paper only! Consider the way we are divided. Some of us are victims of the fraud of "lip-service" democracy; others are accomplices in the guilt of idly standing by and thereby lending our tacit approval. Reflecting on this, one need not ask why we have not yet approached optimum mental health!

Let us be mature enough to admit that we have failed to make our democracy work on at least many occasions and in many places and for many people. Let us at the same time remember that the fault is not and has not been with democracy, as a way of life, but rather with us citizens, who have shirked and neglected our duties. Let the psychiatrists who know the destructive effects of undemocratic ideas and practices upon the mental health of the community speak out; and let those who do not yet know, start to learn!

During the war most of us Americans learned how to bury our hatchets in the enemy instead of in one another's backs. Management and labor, in pre-war years so often at opposite poles from each other, have proved that sane men can unite and accomplish "miracles" when they so make up their minds. American industry and labor can truly be proud of their war record and the rest of us can well applaud. Admitting that there have been some extremely tragic exceptions, it can, nevertheless, be said that interracial and religious coöperation has made considerable strides forward.

But the shooting phase of the war is only the first stage of the victory. Having won on the field of battle, it would be the height of national suicide were we to return to the

pre-war scene of intergroup tensions and animosity. Both management and labor have everything to gain by continued unity in the post-war period—and the country as a whole, will gain thereby. Likewise, interfaith and interracial good will and mutual respect are of fundamental importance if America is to play its rôle in the post-war world effectively.

It is abundantly clear that the problems of mental health and the problems of democracy are intimately interwoven. Measures that will promote the one will promote the other. But this calls for enlightened men and women with courage to act upon their convictions and with a tenacity of purpose. The task is not a simple one. "It is a ticklish matter," says Dunham "to interfere with the cultural life of a community, and far more difficult to try to effect any change in unwholesome situations, especially when most of the social forces in the community may be against anything new."[1]

Yet after the victory has been won, the job must be tackled. According to Strecker:

> "The second job looks toward the rainbow of the future—that future when democracy will no longer be imperiled; when it will want to consolidate its gains, the more dearly prized because they will have been so hard won. Then, as now, mental hygiene will be sorely needed—needed to educate in humanitarian and spiritual terms, to teach less about the human products of the past and more about how to liberate human intelligence and sympathy."[2]

And, in similar vein, the late C. Macfie Campbell wrote:

> "There can be no exalted national morale if the majority of the individual citizens are exclusively preoccupied with material gains, egoistic satisfactions, rivalries, and prejudices of varied nature."[3]

Ruggles calls upon psychiatrists to take a prominent part in the leadership of social planning. But the psychiatrists alone cannot do the job. "To correct unwholesome social conditions the coöperation of the home, the church, the school, and the lawmakers is absolutely essential."[4]

[1] See "Ecological Studies of Mental Disorders," by H. Warren Dunham. MENTAL HYGIENE, Vol. 24, pp. 238–49, April, 1940.

[2] See "Mental Hygiene and Mass Man," by Edward Strecker. MENTAL HYGIENE, Vol. 25, pp. 4–5, January, 1941.

[3] See "National Morale," by C. Macfie Campbell. MENTAL HYGIENE, Vol. 26, pp. 177-94, April, 1942.

[4] See "Psychiatry in Social Relationships," by Arthur H. Ruggles, in *Therapeutic Advances in Psychiatry* (Philadelphia: University of Pennsylvania Press, 1941), pp. 27-35.

By this time there should be no argument, other than that it is perhaps "too late for adults" and that we must concentrate only on the youth of our country. True, we must concentrate on the youth, but we cannot and dare not neglect the adults—not only because parents "set the pace" for children, but because the adults of our country are not exactly cadavers. They can think and they can talk and they are obliged as good citizens to think and talk in behalf of a truly democratic way of life.

In his report on the work of the National Committee for Mental Hygiene for the year 1942, George S. Stevenson stated:

> "A look ahead confronts us with many challenges. Where shall we find stable peace? How shall we prevent ourselves from slipping back into the old ways of the past twenty years with its Ku Klux and lesser Fascist manifestations? Shall we continue to look for righteousness only in those who are like ourselves—white, Gentile, Democrat, or however we classify ourselves? . . . Can we not find the differences in people a basis for satisfaction that we miss when we look only to the images of ourselves? There is no time to lose. The news from the battlefronts is good. We must hasten or still better news may find us unprepared."[1]

The challenge that confronts us, as a democratic nation, is clear. There are only two questions: Do we *mean* to be democratic or do we not? And if we are not hypocrites—if we are not children walking about in clothing for grown-ups —are we ready to assume our responsibilities and act?

We have the problem, we have much of the necessary information, we have the inescapable responsibility. Have we the integrity, the social consciousness, and the resolution to act?

[1] See "The National Committee's Part in the War Effort," by George S. Stevenson. MENTAL HYGIENE, Vol. 27, pp. 33–42, January, 1943.

NEUROPSYCHIATRY FOR THE GENERAL MEDICAL OFFICER *

EVERY medical officer, regardless of his mission, whether it be battalion surgeon, ward officer, flight surgeon, or dispensary physician, is confronted with psychiatric problems. There is an inadequate number of psychiatrists, and, furthermore, not only must the average medical officer do most of the *minor* psychiatry in the army, but in some instances he may also be forced by circumstances to do *major* psychiatry. Psychiatric treatment, like surgical treatment, is most effective when carried out early, promptly, and skillfully. Consequently, some of the best psychiatry will be done outside the hospital in such places as the dispensary, the consultation service, the battalion aid station, the clearing station, and the air strip. Because most medical officers have inadequate training in the field, the suggestions in this paper are presented as a general guide.

Mental health is chiefly a command responsibility. It is intimately linked with the effectiveness of motivation of the soldier, and the number of neuropsychiatric casualties is directly related to good leadership and the state of morale. Regardless of the leadership or the state of the morale, in the building of an army and using it in combat, there will be psychiatric casualties, and it is the medical department's duty to evaluate these, treat them, and make appropriate disposition.

Incidence of Psychiatric Problems in Army.—At induction stations, psychiatric rejections have constituted from 10 per cent to 20 per cent of all rejections.

Statistics of hospital beds occupied by neuropsychiatric cases never include the functional (psychogenic) illnesses on general medical and surgical wards. Incidence of functional disturbances on general medical and surgical wards varies. Even in the final hospitalization in named general hospitals,

* War Department TB Med 94, September 21, 1944. Prepared in the Neuropsychiatry Consultants Division of the Surgeon General's Office.

studies indicate that 25 per cent to 50 per cent of the cardiovascular cases, 10 per cent to 30 per cent of the gastrointestinal cases, and 5 per cent to 15 per cent of the orthopedic cases are functional.

Neuropsychiatric casualties constitute an important portion of combat casualties, the percentage varying with the intensity and duration of combat. Sufficiently severe and sufficiently prolonged combat can produce decompensation in the strongest of personalities. Some neuropsychiatric casualties are due to poorly integrated personalities, and others result from excessive stress.

Classification of Clinical Responses.—Classification of clinical responses from the psychiatric viewpoint as observed in a hospital are:

1. Strictly organic conditions (infection, operative cases, trauma) in which the emotional difficulties may be an important factor in the recovery. The wish of every normal man to escape combat may be gratified by physical illness or wound, and thus in certain persons have definite psychiatric implications.

2. Border-line physical conditions (gastric ulcer, allergic manifestations, hypertension). In these, emotions play an important rôle, not only in association with the causes, but equally in the prolongation and treatment.

3. Physical complaints as the expression of emotional disorders. Gastrointestinal, cardiovascular, and orthopedic symptoms are examples. These are automatic and no more under the voluntary control of the patient than is a facial tic.

4. Predominantly psychic syndromes. Anxiety, fear, obsession, hysterical conversion symptoms, psychosis.

5. "Psychopaths." Behavior disorders and situational responses such as are found in the so-called "psychopaths," with conscious exaggeration of symptoms, malingering, "simple adult maladjustment."

Medical Officer's Attitude.—The medical officer's prompt and effective management of the neuropsychiatric case will be scientific in direct proportion to his understanding of himself as well as his patient. The officer who resents his own position in the army, or who has unrecognized personal conflicts, is most likely to have an emotional attitude, most

often a resentful attitude, toward the neuropsychiatric casualty. This understanding, or lack of it, can best be demonstrated by various attitudes displayed toward the psychiatric patient:

1. Objective and sympathetic understanding.

2. Overhospitalization and overexamination of the patient from a physical point of view. This is usually due to the medical officer's confusion, and may be expressed in his abuse of sedatives and placebos.

3. "Coddling." Some medical officers identify with the patient so closely that they are oversympathetic, overindulgent.

4. Failure to recognize the medical nature of the problem and the tendency to indicate to the patient that there is "nothing the matter with him."

5. Indifference on the part of the medical officer, usually because of a failure to appreciate the problem or lack of a sense of responsibility regarding it, with the result of either ignoring or neglecting the patient, or being apathetic toward him.

6. Scolding or kidding the patient. In either case the medical officer belongs to the "buck-up" category. Encouragement of the patient is often indicated, but such cannot be provided by these methods.

7. Annoyance on the part of the medical officer, with a mildly vindictive response, often with public deriding of the patient. This rarely may progress to an expression of anger toward the patient, accusing him of cowardice or evasion of duty.

Causes of Mismanagement:

1. Educational basis. Few medical schools teach sufficient psychiatry to enable a medical officer to evaluate personality disorders. The result is a lack of confidence in his own ability to handle even simple psychiatric problems. Some woefully ignorant medical officers even fail to regard such patients as medical problems—a revelation of the lack of comprehension of the physician's rôle.

2. Emotional basis. An emotional attitude toward psychiatric problems often has its origin as a self-protective device on the part of the medical officer. This device has

special significance in the army, where some medical officers consciously resent their situation in the army, their separation from home, their economic loss, their possible professional misplacement or inactivity.

3. Relative intangibleness of the material. Psychiatric and psychological findings are as real and valid as those in any other field of medicine, but because they require intellectual perception in contrast to sensory perception, they seem less tangible than the X-ray, chemical data, or surgical technique.

4. Time consumption. To study adequately the personality and, in addition, to examine the body physically requires time. In all organic cases, when a time-consuming diagnostic or therapeutic procedure is indicated, whether it be a glucose tolerance curve or a gastrointestinal X-ray series, the fact that it is time-consuming is not considered in its utilization (except in emergencies). In functional cases, the time required to study the personality should, therefore, not act as a deterrent. Spectacular, immediate, and satisfying results obtained in certain drug therapy and in surgery appeal to many physicians; actually these are no more spectacular than the result to be seen in cathartic psychotherapy under sedation, the results of hypnosis, or the results of electro-shock therapy.

5. Functions of medical officer. Failure of some medical officers to evaluate properly their own function in the army—namely, tc diagnose, treat, prevent, toughen, and, probably most important, create and maintain high morale by seeing that the individual soldier is satisfied, happy, and effective. He may do some of these, but his function should include all of them.

6. Army status. Every officer is subject to the orders of his superior, and his viewpoint and his effectiveness are modified by his superior. Inadequate or poor psychiatry may result when an officer attempts to curry favor with a superior who is unsympathetic toward psychiatry.

7. Lack of experience. Some medical officers are young and have not had sufficient opportunity to learn. Others never do achieve the insight and understanding of the old-fashioned general practitioner who knew the details of the

living habits of every member of the family. Officers without combat experience have far less understanding of the battle casuality than the man who has lived under combat conditions.

Errors to Be Observed and Avoided:

1. Failure to assess the emotional factors. Frequently the medical officer fails to assess adequately or correctly the relative importance of the psychological and physical factors in the disease. Too many assume the "either-or" attitude—that the illness is either physical or mental—instead of considering how much of the picture is contributed by somatic pathology and how much by psychological pathology. The net result of this failure to assess is a diagnosis arrived at by exclusion—by a negative rather than a positive approach.

2. Failure to take an adequate history. If we are to learn to know the person as well as his disease, we must of necessity learn his background. It is far more important to learn the individual's relationships with the parents than it is to note merely his age and state of health. Particularly in the army we need to know an individual's pattern of reaction to stress, his successes and failures in adjustment in relation to people, school, and jobs. Without an adequate history, the personality cannot be evaluated.

3. Failure to establish rapport. Too often the medical officer never appreciates the necessity for learning to know the patient and not merely his disease or his complaint. As a consequence, he never establishes a rapport with the patient; the patient never feels his sincerity or his interest. It is often said that the patient does not know the cause of his difficulty, but he knows how he feels, while the medical officer may know the cause of the difficulty, but he does not know how the patient feels.

4. Failure to note particular emotional stresses in the army. A medical officer may fail to recognize the importance of the particular emotional factors in army personnel—namely, the readjustment demanded in the change from the security of family, home, and friends, and a free existence, to the regimentation, the discipline, the isolation, and the tough existence in the army. Every soldier's problem should be evaluated in terms of the stresses in the army which are

not comparable, either in type or degree, to those seen in civilian life.

5. Overexamination. Many patients with functional complaints are given excessive laboratory and X-ray examinations as well as other types of test, particularly by younger medical officers, with the result that too often the patient ends up by feeling that he has a serious and mysterious problem, or else that he has succeeded in misleading and thus making a fool out of the medical officer.

6. Overhospitalization. When a patient appears as a difficult diagnostic case, as so many functional illnesses may turn out to be, the patient is kept in the hospital far too long. By such a procedure, all too often his symptoms become more fixed and better crystallized. When and if overemphasis is placed on a particular finding—such as a slightly lowered blood pressure, a minor cardiac irregularity, or an indefinite shadow in the X-ray—this serves to convince the patient of the organic nature of his illness, even though such is not the intention of the medical officer.

7. Overemphasis on a physical treatment measure. To place a patient who has a functional disorder on a special diet as if it may have some magic quality, to direct special attention to his bowel movements, to apply a back-brace, or to employ some other procedure or appliance that has no real relationship to the nature of the soldier's illness, greatly reinforces the patient's conviction that his illness has some physical basis. While such procedures may have a valid psychotherapeutic value in some cases, many others will grasp at them with avidity as if they were a vindication of their own interpretation of their problems. In functional cases, special care should be used in the employment of such procedures.

8. Mistaken diagnoses. Even though functional illnesses are often given an organic diagnosis, the opposite mistake also occurs. Occasionally a medical officer—certainly among them psychiatrists—sooner or later labels a patient with a brain tumor as a psychoneurotic because the patient's difficulty appears to be functional, and because the medical officer "believes" it to be so. When treatment is based on such assumptions, sooner or later a tragedy will occur. The acute

onset in a large percentage of pancreatic tumors begins with mental symptoms. Brain tumors most often begin with mental symptoms which are frequently psychoneurotic in character.

Every medical officer should recognize, particularly in psychiatric problems (functional illnesses), that the labeling of such a patient with a diagnosis that is unjustified may be the first step toward making that individual a permanent invalid. A diagnosis is nothing more than a scientific label which patients rarely understand and often misinterpret. "Cerebral hemorrhage" is much more ominous in its sound than "stroke." The diagnosis of psychoneurosis, so often misused, is far more ominous sounding than "nervousness." It is far more important to explain to a patient the nature of his illness than it is to give him the name of it, and definitely harmful to do the latter without the former.

9. Failure to consider patient's feelings. Too often the diagnosis and disposition of a patient are discussed bluntly and without feeling in his presence and in the presence of other patients, leading to embarrassment, inferiority feelings, or resentment. Depending on the medical officer's attitude, this may be extremely harmful, particularly if the medical officer's own emotions are involved in the problem; he may be vindictive or threatening or may forecast to the patient a bad prognosis. Occasionally he promises much more than can be delivered, in the form of a discharge, an assignment, a transfer, or a furlough—procedures over which he has no authority.

10. Failure to work as a team with other specialists. Too often a medical officer in a particular specialty, such as surgery, medicine, and psychiatry, is inclined to isolate himself from the other groups, taking little or no interest in the problems of the other specialists, even though they may have a major influence on his own practice. Some medical officers appear to be proud of their ignorance of other fields, and this is particularly apt to be true of these officers in their attitude toward psychiatry. Even though they need not know the techniques of *major psychiatry,* they should know *human nature*—the psychological factors in illness—just as they should know the chemical and anatomical factors.

11. Overemphasis on statistics. In dealing with great masses, with rapid turnovers, statistics are essential. But statistics never tell the whole story. A medical officer may pride himself on the low hospital admission rate or the low C.D.D. rate, and it either case they *may* represent merely bad judgment and poor medicine. Recently special interest has been manifest in statistics revealing the number of men "salvaged," which may represent the facts, or merely the noneffectives in some unit. The medical department's function and goal is to maintain the health of the command, and this cannot necessarily be judged by how it appears statistically.

Misconceptions Regarding Psychiatry.—In the minds of most medical officers, no field of medicine has more mystery, more bugaboos, more misconception, than psychitary. Unfortunately, these misconceptions are frequently held by the medical officer, and often the fact that he is a physician and is supposed to be well informed makes him hold more tenaciously to certain misconceptions than the average intelligent layman. Some of these misconceptions are as follows:

1. Misconception: that a neurotic reaction is a conscious and often a feigned state.

Correction: The true neurotic symptom never constitutes a *conscious* excuse for escaping a problem and, therefore, is *not* malingering. In many instances the basic complaint may be capitalized upon somewhat to aid in the achievement of a conscious desire, but this should not confuse the issue. A neurosis is an illness. Neurotic reactions in the army are no different from those seen in civilian life. In all cases, the patients themselves are entirely ignorant of the real basis for their symptoms, and as long as they remain so, are wholly incapable of controlling them. Even so simple and obvious a symptom as a myoclonic facial tic cannot be controlled. Likewise, cardio-spasm, lumbar-muscle spasm, and many other symptomatic complaints are beyond the patient's conscious control.

2. Misconception: that neurotic reactions occur only in abnormal or predisposed people.

Correction: All individuals at times show neurotic symptoms; even severe neuroses should not be regarded as constitutional or inherited illness. A constitutional factor is

present in certain types of mental illness, but environmental factors are far more potent in the cause of these reactions.

3. Misconception: that malingering is common.

Correction: Malingering, the intentional simulation of an illness in an individual without physical or psychological defects, is not common, occurring in a very small percentage of all hospital admissions in the army. Moreover, malingering is a psychopathological symptom, often only one symptom of an individual's basically unsound personality structure.

4. Misconception: that an individual who had a neurotic or a psychotic illness is permanently incapacitated.

Correction: Many people who have had severe mental illnesses recover entirely and permanently. The recovery rate even for cases sent to our state hospitals runs as high as 40 per cent; and the earlier the cases are recognized and treated, the higher is the recovery rate. In one theater, 80 per cent of the psychiatric casualties in combat returned to duty.

5. Misconception: that all mental illnesses appear similar or merely gradations of one another.

Correction: There are many very definite, specific clinical entities and they differ from one another as distinctly as measles differs from pneumonia. Some affect primarily the perceptional faculties, others the intellectual faculties, others the emotions, and still others the behavior. There are still other deviations in the type and degree of the involvement of these.

6. Misconception: that the neurotic soldier can be forced or threatened into being an effective fighter.

Correction: The neurotic soldier is as much incapacitated and as ineffective as a physically ill soldier. Threat or punishment will invariably make him worse, as well as justifiably embittering him toward the army and his officers. This does not negate the fact that mild neurotic reaction and those situational responses that occur in training as well as in combat can be given support, and the individual greatly aided. One must keep in mind that, in combat, illness may be regarded as an asset and a helpful liability because it serves as a means to escape combat. Therefore, firmness and

positive reassurance are indicated under such circumstances.

7. Misconception: that all soldiers with neurotic reactions should be discharged.

Correction: Many neuroses are mild in nature and the soldier recovers from the disabling symptoms if treated properly. Often moderately severe neuroses can be alleviated, and such men can render useful service in the army. They should not be placed in combat situations. A high percentage of soldiers who develop neuroses in combat can be returned to full duty if treated early and effectively.

8. Misconception: that enuresis is a silly habit, which any man can control if he so wishes.

Correction: Enuresis, in nearly all cases, is evidence of a personality developmental defect and, in most instances, is entirely beyond conscious control. Its successful treatment in adults is very difficult. Unnecessary instrumental genitourinary investigations tend to fix the symptoms as well as to convey the impression that the problem is organic.

Psychiatric Concepts:

1. "Normality." As applied to mental activity (thinking and feeling), the term "normal" includes a wide range of reaction, depending on the individual and his environment. Thus a belief or action may be normal for one individual and grossly abnormal for another. An example of the influence of the immediate environment is seen in fear, which is "normal" in combat. Psychopathology exists when the efficiency, the physical and emotional well-being, the social behavior, or the individual's thinking deviates beyond the socially accepted limits in a specific situation.

2. "Conflict." Cultural, social, and educational influences serve as a constant curb to primitive instincts and personal wishes. These two opposing forces are always in conflict, modified by the individual's life experience and habits of reaction, and by the nature and pressure of the external demands. Psychopathology, like proud flesh, is a faulty response to the conflict; it represents an unhealthy compromise, an effort to establish an equilibrium between opposing forces. Every individual develops well-recognized and well-defined automatic devices in an effort to maintain this equilibrium. Thus, to repress his own anxiety in a con-

flict situation, an individual may become suspicious, blaming other people for his failure, a device known as projection. An individual may justify an unreasonable belief or attitude or behavior by what seems to be a logical explanation, a device known as rationalization. There are many of these mechanisms, all of which function automatically and without conscious understanding or deliberate purpose on the part of the individual. All of them represent unconscious escape mechanisms which operate to protect and excuse the failure of the individual.

3. Total-response concept. The individual reacts as a total unit—physically, chemically, psychologically—to environmental demands, whether these demands include bullets or bacteria, a new job or a new wife, the army or civilian life. If the individual fails in his adjustment to these environmental demands, he may become sick, and this sickness may be expressed predominantly through one medium more than another—that is, physical, chemical, or psychological. Commonly all three media are involved in the total response. Consequently, in examining a sick man, equal scrutiny must be given to the importance and the nature of each of these three factors.

4. Modifying factors. Factors modifying the total (physical, chemical, emotional) response of an individual are:

(a) Constitution. Heredity is an important, but an unknown influence, probably more significant in the response to physical illness. It is impossible to separate factors due to the inheritance from those resulting from the early environment.

(b) Environmental influences during development. Early training and experience are the most potent factors in determining character traits, automatic response patterns, personal relationships, loves, hates, choices, prejudices, etc. Specific patterns of reactions and attitudes are established in infancy and childhood which largely determine subsequent attitudes toward people, ideals, ethical and moral attitudes, and methods of solution of conflicts.

(c) Precipitating factors. Some event, some person, some special situation often serves as a threat to one's sense of security; and this threat, either minor or major, may act,

like a catalytic agent in chemistry, to initiate the train of maladjustment in the susceptible individual. Such an incident or situation appears to be the cause of the maladjustment or sickness. Thus an emotional loss, a threat to life, a pneumococcus invasion, or a bullet may start a train of more complicated reactions which we call illness.

5. Interrelations of the soma and the psyche. We have long been familiar with the physiological responses to acute emotional stimuli, such as fear. Less commonly is the relationship between emotions and physical symptoms recognized in their less acute expressions. There is no doubt that homesickness can cause gastrointestinal symptoms, even to the extent that the individual is entirely concerned with his gastrointestinal symptoms. Similarly, suppressed resentment may result in cardiovascular symptomatology. In the total response in sickness, the bodily systems frequently express unrecognized emotional distress. In the army, the medical officer cannot help but be impressed—perhaps because the patients are seen earlier—by the fluid state that exists between the emotions and the physical systems.

In all cases, anxiety is first mobilized; in some instances this is converted automatically into physiological manifestations affecting some organ or organs of the body. In its most bizarre form it is known as hysteria, in which the conversion symptom may even assume the proportions of paralysis, blindness, or anæsthesia. When anxiety is converted to physical symptoms and persists over a long period of time, organic pathology *may* result. Thus, there is considerable evidence for the belief that peptic ulcers may experience some such evolution, as also certain cases of hypertension, allergic responses, and skin eruptions.

6. Significance of functional (neurotic) responses. It is essential to recognize the automatic, uncontrollable nature of the somatic responses to psychic stimuli. This is generally recognized in blushing, habit spasm, and stuttering. In all instances it represents a compromise situation, an attempt to meet a conflict, only a portion of which at most is recognized by the patient. Basically, the primary purpose of such symptoms is to gain relief from tension, security, or affection. Always, in such conditions, however, the secondary

purposes are acquired and capitalized upon because of the presence of the symptoms—namely, the special care and consideration accorded invalid states, immunity from responsibility, acquisition of time, money (pension), and escape from duty. Functional symptoms thus have a purpose in *partially fulfilling* basic needs of the patient—partially defending him against threatening forces. Thus, he may make his adjustment. Individual specific meanings of the symptoms must be discovered by careful observation and reconstruction. Theoretical explanations for such are possible at many different levels, since motivation is varied and complex. For example, when a soldier's life is threatened in combat, there are many delicate balances to be maintained in order to keep him at his job. Prestige values, individual fellow-soldier ("buddy") loyalties and supports, the soldier's own evaluation of the worth-whileness of the particular operation, deep-seated family ties, belief in the essential righteousness of his cultural group, and many other factors must all be maintained.

7. Fixation of symptoms. Because of the primary and secondary gains from the neurotic illness, many individuals find life more satisfying when ill than when well. The gains resulting from their illness are more than they have when they are well. In general, the longer the symptomatology has existed, the less favorable the prognosis. This is of special significance in the army, particularly in combat, where in many instances the neurotic solution of a difficulty first develops. Consequently, the heavy sedation of a battle casualty tends to hold the individual in an "amorphous" state and to prevent the fixation of neurotic symptoms. Custodial hospital care afforded to such patients encourages the fixation of the symptomatology. Technical psychiatric jargon and even the diagnosis may be utilized by the patient further to advance and to maintain his position.

Psychiatric Approach:

1. Physician-patient relationship. The majority of medical officers, after varying periods of self-adjustment, realize the opportunities for service in the army in keeping the vital man power of the army at peak efficiency. To quote the Surgeon General, "The human relationship of the doctor,

patient, and family cannot be laid aside with the donning of the uniform." To understand the illness as a whole, one must know the patient as a whole—his hopes, his fears, and his anxieties. In short, the medical officer must know his soldier-patients as persons. The psychological reaction to organic illness may be of more importance than the illness itself in terms of future disability. And certainly the prompt recognition and early treatment of neurotic disorders may, and often does, prevent long-continued illness.

Many devices may be used, in addition to the personal technique, to indicate to the patient the medical officer's sincere interest in him. He may explain certain aspects of the patient's problem to the nurse or to the attendant in the presence of the patient (taking care not to give confidential data). He may inquire into the patient's personal needs or desires. Under certain circumstances he may be able to consult and advise the company or battalion commander about the patient in the patient's presence.

2. History. The approach, in taking the history, toward the illness itself, must be a positive one. The statements regarding the symptomatology *should not be negative ones* only, and not arrived at by mere exclusion. Every specialist should primarily be a general practitioner, first, last, and always, so that the initial approach to a patient is one of despecialization, and includes keen interest and regard for the individual—a person who is ailing, not merely a disease. This may be accomplished by many techniques. In general, first let the patient talk about his present problems. Then let him describe the more remote contributing factors to the picture—his past life, his educational and vocational experience, and last, but perhaps most important, his family relationships, both in his childhood and at the present time. What attitude did he have toward his father, his mother, his siblings, and they toward him? Most important information is obtained only through cautious and careful investigation of certain spheres of human activity—namely, religious experience and beliefs, sexual experience and practice, special relationships to women or to men, recreations or hobbies.

Psychiatric Evaluation.—In addition to the history, the astute and intuitive medical officer learns much from *obser-*

vation of his patient—his mannerisms, expressions, methods and content of ordinary conversation, attitudes toward those about him and toward the present situation. Of equal importance are the psychological observations that are possible in the course of a physical examination, using the latter as a vehicle for learning about the psychological status. Some patients have reactions easily observable in response to undressing, to the laboratory examination, pain responses, reaction to the examination of the genitalia and rectum.

Other than obtaining the facts in the history described above, it is not likely that the average medical officer will take the time to make any systematic psychiatric examination. Nevertheless, this can be accomplished quickly under five general heads:

1. General reaction. The patient's *general reaction,* including the situation, his responses, his appearance, his attitude toward the examination.

2. Perception. The degree of clarity of thought or cloudiness, confusion, mistaken perception (illusion).

3. Intellection. Mental content (the patient's "story"), insight, fixed ideas, mistaken ideas, intelligence.

4. Emotions. Excesses or deficiencies of any particular type, degree of fluctuation, specific forms such as fear, excitement, anxiety, depression.

5. Action. The spontaneous action in the immediate situation including behavior, eating, sleeping, and excretory habits and other activities.

Hospital Methods:

1. Early consultation. It is most advantageous that an early psychiatric examination be made. This should not be delayed for laboratory X-ray and other investigative procedure, with the idea of establishing a diagnosis by exclusion. In line with this whole treatise, the average medical officer should become competent to handle all but the severe psychiatric problems.

2. Preparation of individual for neuropsychiatric consultation. Physicians often find it difficult to refer a patient to the psychiatrist. Most intelligent patients can be helped to recognize that emotion can, and often does, cause physical symptoms. Often the patient is helped by reorientation and

education regarding the function of the psychiatrist. It may be emphasized that less than 10 per cent of the psychiatrist's work is concerned with severe (psychotic) illnesses; that his major interest is in patients like the one being referred; that he is an expert, a specialist, who may be of enormous help in the problem at hand; and that a psychiatrist is truly and sincerely a physician in the best sense.

3. Consultation blank made out by referring officer. Any consultation is greatly facilitated if the officer in charge works up the case to the best of his knowledge within the field of the consultant. For neuropsychiatric consultations, a special blank has been developed in many hospitals. The referring medical officer should formulate the problem clearly and in detail, giving factual data and specifically stating the nature of the information and opinion desired. There is no value in sending the consultant on a hunting trip, nor should one expect him to engage in a guessing game. For the purpose of facilitating the consultation as well as assuring that mutual benefits may be derived, the consultation should be held personally with the ward officer, who requests it.

4. Joint staff rounds. Where time and facilities have permitted it, great advantage has been derived in our army hospitals from joint staff rounds of psychiatrist and internist or surgeon. These may be held at regular stated intervals. In a few hospitals, great benefit has been derived from mutual exchange of ward officers for short periods, psychiatrists serving on internal medicine or in surgery for a period of one or two weeks and internists and surgeons serving for a similar period on the neuropsychiatric section.

Special Psychiatric Problems in Army.—It is recognized that army psychiatry differs in some ways from civilian neuropsychiatric practice, and from general medical and surgical practice. Moreover, there are special psychiatric problems related to aviation, to paratroopers, to tank soldiers, and to submarine workers. In the army such factors as discipline, regimentation, isolation, and strenuous physical demands result in a few specific psychiatric problems which deserve special comment.

1. The "gold brick." A thoughtful medical officer does

not lightly impugn the integrity of a patient by referring to him as a "gold brick." Evasion of responsibility by the soldier, by feigning illness or conscious exaggeration of a complaint, must be met with stern discipline and firm professional judgment. To permit such soldiers to escape hardship by fraudulent and conscious design is not merely unjust, but it encourages similar behavior by others. It is the consensus of experienced psychiatrists that true malingering, which is the conscious and deliberate feigning of illness to escape duty, characterizes only a very few of the patients who are referred to as "gold bricks." Careful inquiry usually reveals that such patients consciously exaggerate previously existing complaints as a result of anxiety or fear.

The essential characteristic of every psychoneurotic reaction is that it represents an unconscious resolution of conflict and therefore serves a purpose. The purpose, however, is unconscious on the part of the patient, and the fulfillment is frequently mistaken by the medical officer as a conscious evasion. To classify such a patient as a "gold brick" is not only scientifically inaccurate, but is also prejudicial to his welfare. Understanding by the medical officer of the painful situations that cause the soldier's emotional conflicts and the interpretation of this understanding to the patient in skillful and acceptable terms is a necessity. Understanding of the nature of emotional mechanisms by the medical officer frequently provides the key to therapy. Improper therapy often produces chronic lifelong invalidism, and proper therapy may transform an ineffective neurotic patient into an efficient soldier.

2. Malingering. Malingering is related most often to a personality defect much deeper ingrained than neurotic manifestations, and is generally included under the diagnosis of "constitutional psychopathic state." Unfortunately, true malingering, in this sense, is extremely difficult to prove and unless incontrovertible proof is offered, the charge cannot be sustained. For the sake of the morale of the group, instances of true malingering are best handled in the army by disciplinary measures.

3. "Psychosomatic" illnesses, including particularly gastrointestinal, cardiovascular, and orthopedic cases. The term "psychosomatic" in the broad sense refers to all of medicine,

and its use is not necessarily restricted to specific cases or types of case. In many instances it is applied particularly to those illnesses in which emotional factors produce and are represented by physical functional disorders. The great frequency of such cases in the army cannot be interpreted as necessarily indicating that they are not as frequent in civilian life. However, it may be that in the army such cases are conspicuous because of environmental circumstances and because the patients consult the medical officer.

4. Surgical problems. Cautious surgeons prefer to have a psychiatric consultation in all cases of elective surgery, and this procedure is particularly indicated in the army. Many individuals will express their neurotic maladjustment by complaints of pain around a post-operative scar, or weakness, "pulling" or "drawing" sensations. This is specially important in instances of hernia, varicose veins, pilonidal cysts. Special psychological evaluation is indicated in individuals who refuse surgical operation, and grave doubt arises in the majority of instances as to the future value of such a soldier.

5. Purposeful accidents. Many surveys have shown beyond doubt that certain physically normal individuals are "accident prone." In every industrial plant a large majority of the accidents occur and recur in a small percentage of the employees. Such individuals are known to have a specific personality distortion, often amenable to therapy. In the army, self-inflicted wounds in many instances are unconscious-inflicted—though, none the less, purposive—accidents. As in the case of malingering, it is almost impossible to prove conscious intent in self-inflicted wounds. Even if it could be proved, it is doubtful whether the soldier could be rendered effective again. As with other neurotic symptoms, supporting, restraining influences are effective to a limited extent. Consequently, the knowledge that an investigation will take place in case of self-inflicted wounds tends to decrease their incidence.

6. Organic causes of frank psychiatric syndromes. Because of the high incidence of psychiatric syndromes, the medical officer needs to remind himself continuously of the necessity of a total examination and evaluation of the patient in the anatomical, chemical, and psychological spheres. Too

frequently psychiatric syndromes due to exhaustion, post-infectious state, delirious reactions, are regarded as being functional in nature. Particularly important in field operations is the transient effect of fatigue and the related causative factors of inadequate diet, lack of sleep, and prolonged emotional tension.

7. Diagnostic categories. If we omit the minor situational maladjustments and the minor psychopathology of every man's daily life, neuropsychiatric problems can be roughly divided into five general groups:

(a) Psychotic responses (psychosis, both organic and functional). Characterized by disorganization of the personality, usually with loss of insight (recognition of the severity and the significance of their symptoms) and always accompanied by various forms of reality distortion as shown by delusions, hallucinations, or illusions.

(b) Neurotic reactions (psychoneurosis or neurosis; "nervous breakdown," nervous exhaustion," "operational fatigue," "combat fatigue," etc.). Characterized by a wide variety of symptoms, but without gross distortion of external reality. Symptoms represent compromise reactions, such as conversions, obsessions, compulsions, phobia, anxiety, and physical complaints. An individual may have obvious neurotic reactions, but these do not necessarily justify a diagnosis of psychoneurosis.

(c) Defects in character development. Antisocial or unconventional behavior with absence of appropriate emotional response. These individuals do not have "symptoms" in the ordinary sense of the word, but their behavior is always out of line—petty offenses, repeated AWOL, lying, stealing. These are usually diagnosed as "constitutional psychopaths."

(d) Feeblemindedness. An organically caused mental retardation in varying degrees with or without neurotic or psychotic symptoms.

(e) Organic neurological conditions. Not grossly effecting or producing personality changes, including the inflammatory, traumatic, neoplastic, degenerative, and infectious illnesses.

Treatment Principles:

Nature of psychiatric treatment. Many medical officers

have a vague conception of what constitutes psychiatric treatment or what procedures are included in it. In all cases the approach is toward an attempted amelioration of the symptomatology by changing the individual or the environment or both. Attempts to change the individual include psychotherapy (see below), rest, shock, sedation drugs, and a prescribed program of activities, including occupation, education, recreation. Attempts to modify the environment may include a direct manipulation of the soldier's environment by the medical officer, recommendations concerning ways to live in it, utilization of the Red Cross in family problems, explaining the patient's problem to company officers or noncommissioner officers, recommending to the commanding officer that the soldier be reassigned or reclassified, or transfer of certain types of individuals to more congenial surroundings. It is important to recognize the potential efficacy of many simple, available procedures and techniques applicable to both inpatients and out-patients.

Psychiatric treatment, like surgical treatment, is most effective in most cases when given promptly. The longer it is delayed, the less optimistic is the prognosis. Prolonged hospitalization is harmful to the majority of psychoneurotic patients. Treatment for most psychiatric disorders must be given by the average medical officer, whether he be internist or surgeon, cardiologist or dermatologist, and only the more severe psychiatric problems need be referred to the psychiatrist.

2. Psychotherapy. In the broad sense, all the medical officer does for the patient, including the taking of a history and performing the physical examinations, may be regarded as a kind of psychotherapy. Strictly defined, psychotherapy refers to the release of anxiety through free discussion leading to understanding. There are two general types: expressive ("free and adequate drainage") and suppressive (encouraging "encystment"). Where possible, the former is preferred, although the latter is often more expedient. Specific psychotherapy can be administered in various ways: through catharsis (merely letting the patient "get it off his chest"), suggestion, education with orientation, reassurance, persuasion, and even by command. Psychotherapy under

partial sedation is a procedure that ordinarily should be delegated to the experienced psychiatrist, in whose hands it may prove a very effective method of releasing inhibition, facilitating catharsis, and freeing acute anxiety, particularly in the case of battle casualties.

Many patients with physical illnesses need psychotherapeutic aid, some through reassurance, some with studied neglect (a form of withholding obvious attention), some with firm and positive direction, and every one with the opportunity to recognize the sincere interest of his medical officer. Many psychiatric patients need physical treatment and this should go hand in hand with the psychotherapy. One must carefully avoid the "either-or" attitude in treatment, that is, giving either psychotherapy *or* physical treatment (drugs, operation). Both the patient *and* his disease must be treated.

3. Treatment in battle conditions. From all theaters, we have learned that the most effective initial treatment for psychiatric casualties is immediate sedation provided at the aid station, collecting station, or clearing station, with immediate subsequent opportunity for rest, clean clothes, shave, and bath. These procedures may occupy from one to three days. During this time the patient should be made to understand, if possible, the great need for his return to battle. This is supplemented by an appeal to his pride, his sense of duty, his loyalty, and a positive statement as to the absence of medical justification for evacuation. With such treatment, approximately 50 per cent of casualties can be returned to combat duty.

4. Hospital treatment. Mild and moderately severe psychoneurotic patients should not be kept in the hospital beyond the time required for diagnostic study. Both during and after hospitalization, many patients are very greatly helped by the prescription of a schedule of activities. Such patients should not be permitted to spend their time idly on a hospital ward; they should be provided psychotherapy, occupation, recreation, and education, in addition to such physical reconditioning as they are able to carry out.

5. Discharge. If and when military personnel is recommended for discharge for neuropsychiatric reasons, or with a diagnosis indicating functional illness, the medical officer

has certain special responsibilities. The patient should have a clear understanding of the nature of his illness, what he may expect, and what he can and should do about it. He will be called upon by his family and friends and perhaps even employers to explain the reason for his discharge. It is reasonable to expect that if his intelligence is average, he will want to know the diagnosis. In presenting this, the medical officer should recognize the undue emphasis the patient may place upon it and the misunderstanding that may arise in the mind of the patient or his family if it is not clear. Part of the patient's problem may lie in the acceptance of the diagnosis and the development of a healthy and intelligent attitude toward it. It may help the patient, if the medical officer will:

(a) Explain the universality of functional and emotional symptoms.

(b) Explain to the patient the causes of his symptoms.

(c) Desensitize the patient to the diagnosis by giving him synonyms—"nervousness," "jitteriness," "insomnia"—at the same time making it clear that these *are* synonyms and that they may be more understandable to other people.

(d) Outline in detail any further treatment indicated or recommended, furnishing the patient with references to civilian physicians or clinics.

(e) Aid the patient by pointing out the possible difficulties that may be expected when he gets home: misunderstanding friends, return or intensification of symptoms with frustration or pressure, relief when obstacles are met and dissolved. He may need reassurance regarding his ability to do a civilian job.

(f) Enlist the help of the social workers of the Red Cross to communicate, if necessary, with the soldier's family.

(g) Direct the patient to the personnel consultant officer, who will advise the patient regarding his job asset on the basis of his experience in civilian life and in the army. Vocational and educational guidance will also be supplied to those who desire it.

(h) Challenge the patient to continue his contribution to the war effort as a civilian.

NEEDED: 10,000 PSYCHIATRISTS

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THE so-called nervous, emotional, and mental disorders, commonly grouped together as the psychiatric disturbances, constitute by far the biggest medical problem in America to-day, both in the army and in civilian life. It is a problem that has been too long neglected. Yet to-day as never before these disturbances have forced themselves to the foreground of public and medical attention. Army medical experience is bringing many young doctors for the first time face to face with the importance of psychiatry as a therapeutic discipline. They are beginning to realize from actual experience that the problems created by war will call for a vast expansion in psychiatric training and thereby in professional opportunities. They are beginning to lose some of their prevailing antagonism toward psychiatry as a medical discipline.

The present war has brought to acute focus the high incidence of mental ill health throughout this country. The Selective Service evaluation of some fifteen million men revealed a rejection of 4,217,000, or 28.1 per cent of all the young men examined. Of this group 701,700, or 16.6 per cent, were rejected for nervous and mental disease, and 582,100, or 13.8 per cent, for mental deficiency. Thus 30.4 per cent of the men who were tested for the fighting forces and rejected were found inadequate on one or another neuropsychiatric basis. In addition, 44.6 per cent of all disability discharges from the army, constituting the largest single group of discharges, have been for neuropsychiatric reasons. These figures do not include vast numbers of men discharged for physical reasons in which the emotional component is

great, those discharged for ineptness and undesirable traits of character, and certain other categories that are heavily loaded with psychiatric problems.

The experience of many doctors in the service with the treatment of the "combat fatigue" disorder has shown them the real potentialities of modern psychiatric treatment. Some of these men have indicated their desire for psychiatric training while in the service. Others are already asking about opportunities in psychiatry after the war. This is a hopeful development, for it is a real tragedy that out of our total medical population of 165,000 doctors, a scant 3,500 devote themselves to psychiatric practice. The result has been a serious dearth of psychiatrists to meet the emergency of army needs. It has been estimated that 10,000 new psychiatrists and the same number of psychiatric social workers are needed to provide minimally adequate psychiatric service in peace time in this country. This dearth of psychiatric personnel is not easy to understand because psychiatry offers those doctors who are genuinely interested in human beings a particularly rich and rewarding way of life.

What is required? Psychiatric specialization demands a sound training in general medicine. It calls upon the varied disciplines of internal medicine, neurology, physiology, pharmacology, and many of the other medical specialties for the fullest understanding of psychiatric disorders. Not alone is it related to the basic medical sciences, but it draws heavily upon other allied fields, such as psychology, sociology, and anthropology. This makes for a richness of resources and knowledge unequaled in other specialties.

Modern psychiatry as we know it is barely sixty years old. Because it is a young and new science, it offers unique opportunities for fundamental research into the vast unexplored areas of the human mind. Calling as it does upon the fullest resources of medical science, it combines this with the full range of the cultural activities of man. It utilizes variously the arts—music, painting, sculpture, and so on. It delves into the family and the community. It functions hand in hand with education, political and social science, and all the multiple forces, personal and individual, that go into

the making of modern society. Because of its great breadth, it offers unusual satisfaction to the humanitarian and philosophically minded individual.

Psychiatry no longer concerns itself solely with the grosser mental disturbances. To a far greater extent, it concerns itself with the vast range of everyday medical problems that present themselves to the practitioner—namely, the psychoneuroses and the psychosomatic disorders. Psychiatry is intrinsically related to the practice of medicine, surgery, neurology, pediatrics, gynecology, dermatology, and other clinical specialties. More and more this psychodynamic concept is permeating medical education, and a major part of psychiatric teaching in the future will be done in the medical and surgical services, where it rightly belongs. Whereas, as late as 1930, some medical schools taught no psychiatry, to-day our best medical schools recognize psychiatry as a major science, giving to it the same number of teaching hours as are allocated to medicine and surgery. The next decade will see even greater developments in the methods, content, and time devoted to the teaching of psychiatry and its integration with medical practice.

Training in psychiatry requires a minimum of two years, but increasing opportunities will be available for fellowships, which will pay the physician during the time he is in training. Inpatient training in a psychiatric hospital is the fundamental basis of training. One year of rotating or straight internship must precede this. The fundamentals of psychopathology and psychotherapy are best learned in intimate daily contact with individual patients in a hospital situation over a period of weeks or months. Very soon, however, other aspects of training begin to emerge: basic orientation in neuroanatomy, neuropathology, neurophysiology, and clinical neurology; out-patient experience and the care of ambulatory patients; training in psychoneuroses and psychosomatic conditions as they occur on the medical and surgical services; orientation in child psychiatry, with its emphasis on pediatric problems, on behavioral and developmental difficulties, and on clinical disorders.

Patients are soon seen to function as integrated and indivisible members of their families and communities. Through

modern psychiatric social work, treatment of the family and utilization of community resources become emphasized. Psychological techniques, intelligence testing, personality evaluation, and Rorschach testing are added to the experience. Based on this fundamental orientation gained through actual apprenticeship as intern or assistant resident in a psychiatric hospital, the subsequent training is aimed at responsibility and treatment of non-hospitalized ambulatory conditions.

As the specialty has grown, so have the opportunities for work expanded. Psychiatry has long ago burst from the bonds of the isolated mental hospital. The first of the important developments outside of the state and private hospitals came with the rise of the mental-hygiene concept. Patients needed to be kept well after leaving a hospital. More importantly, the emphasis came to shift to prevention—*i.e.*, the providing of help to vast numbers of people before their condition became critical and hospitalization became mandatory. Now some 227 mental-hygiene clinics throughout the country serve this major function.

As time went on, it became more and more evident that mental ill health in adults had its roots in the imbalances and insecurity of the child. Thus child guidance as a special movement (there are now 127 child-guidance clinics) came to the fore as an attempt to offer remedial aid during the crucial formative years of infancy, childhood, and adolescence.

With these developments, it became evident that many people other than psychiatrists are vitally concerned with the prevention of mental ill health. Some orientation to psychiatric principles had to be available to teachers and educators, since a large part of every child's life is spent under their guidance and influence. Thus, logically enough, mental hygiene quickly spread to the public schools, colleges, and universities, and took its rightful rôle in the teaching and training of educators themselves. Many of our public schools and a number of our colleges and universities have full- or part-time psychiatrists available, creating many opportunities for psychiatric positions in the educational system.

As the principles of mental hygiene became disseminated, the demand for orientation by other groups grew. As early as 1923, industry had recognized this. Preliminary experiments were made by R. H. Macy Department Store, in New York, and the Metropolitan Life Insurance Company. To-day the demands by industry for psychiatrically trained individuals is mounting daily and far exceeds the available personnel. This offers a vast new area of expansion and development within the medical divisions of our major industrial concerns.

With tens of thousands of psychiatrically disabled veterans returning to communities in which psychiatric resources are often inadequate or nonexistent, a new need for "rehabilitation psychiatry" has been created and is thus far largely unmet. More importantly, the rapid advances in the understanding of psychosomatic disturbances will make mandatory the inclusion of psychiatry in any program of comprehensive medical care.

To-day, therefore, the young psychiatrist with training can to a considerable extent pick the opportunity and area in which he wishes to function. For those whose primary interest is in teaching, the medical colleges will offer multiple opportunities in their expanding departments of psychiatry and in the two major areas of internal medicine and pediatrics. For those primarily interested in research, the imminent possibilities of large federal and private endowments and appropriations will offer unique opportunities for an investigative life in the fields of clinical disorders, neurophysiology, biochemistry, electroencephalography, and so on. For those primarily interested in practice, every large city in the country offers unusual opportunities for successful individual practice. A new and enlightened public opinion about psychiatry exists. The demand for psychiatric service and the vastly enhanced sympathy toward the psychiatrist's contribution have created opportunities that far outrace the available personnel.

The psychiatrist as counselor reaches into many other areas: public-health developments, nursery and pre-school organizations, the church and its ministry, the press and the radio—in brief, the entire range of modern society. Thus,

just as a psychiatrist learns something from every patient he treats—whether he be industrial tycoon, college professor, artist, or taxi driver—so in turn must he increasingly share his knowledge and experience with the many individuals and groups other than the strictly medical that now call upon him for orientation and interpretation of human behavior.

There is no dearth of opportunities. The demands far exceed the supply. The financial returns are fully commensurate with those of the other medical specialties. The main reward, however, lies in the particularly varied and enriching qualities of the work itself. Once, therapeutic nihilism could be pleaded as an excuse for lack of interest. With the new developments in the shock therapies, with the accumulating knowledge of dynamic mechanisms, with the constant finding of new techniques of therapy, the outlook becomes increasingly optimistic. Preëminently needed is a genuine interest in people as human beings, a genuine feeling for human beings as individuals, and a determination not to be swayed by prevailing attitudes of disrespect or to be discouraged by a terminology that contains no more unusual words than one easily acquires in one semester of gross anatomy.

For the doctor who has the qualities described and who can learn to make himself articulate, the specialty of psychiatry offers more in concrete opportunity than any other area of medicine to-day. The National Committee for Mental Hygiene stands ready to help and advise any physician who wishes to undertake psychiatric training.

PSYCHIATRY, MENTAL HYGIENE, AND DAILY LIVING*

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IT'S odd, but true that people will consult lawyers, corner druggists, or even radio commentators about their emotional problems before coming to a psychiatrist, and by that time they're often so bewildered and discouraged that advice and treatment are all the harder to give.

Perhaps one reason for this is that many people still think of psychiatrists as specialists who deal exclusively in so-called "mental diseases," and, therefore, that going to a psychiatrist somehow implies that the patient is "neurotic" or "insane." This may have been partly true thirty years ago, but it isn't so to-day. Modern psychiatrists are, first, doctors of medicine, who, in addition, have had long scientific training in understanding man's character, his ways of behaving, his emotional problems, and the methods that can be used in relieving his maladjustments to life and so restoring his physical and mental well-being.

But perhaps, in these stressful times, psychiatrists, like most other doctors, are even more concerned with the preventive side of their science—that philosophy of healthy personal and social living which is usually called "mental hygiene," and which is the subject of this talk. Of course, it's rather difficult to put into only a few words various principles of mental hygiene that need to be applied over a lifetime, but perhaps a few basic ideas will be useful.

The Child.—Let's begin with the child. There is probably no period in life more important in molding a person's character than his early childhood. It is then that he is completely helpless and must look with utter dependence

* Offered as an example of educational material appropriate to radio presentation. The contents of the paper have been recorded in dialogue form for broadcasts in mental hygiene by the Bureau of Health Education of the American Medical Association.

and trust to his parents for all his material and emotional wants. If the parents are too busy with other interests to love their child, or if they disguise their love by rigid feeding schedules or by physical discipline that is too early or too severe, the child develops deep feelings of anxiety and insecurity that may stay with him for the rest of his life. On the other hand, if the parents, out of foolish pride, overindulge and spoil their child, he may grow up a selfish, inconsiderate, demanding person, bound to suffer rebuff and disappointment.

School Days.—Here the upbringing of the growing child should be shared by parents and teachers with coöperation and understanding. It is often forgotten that while the child goes to school to learn from books, it is even more important that he be taught to take his place in groups, to learn tolerance and fair play, to share in coöperative effort, and to acquire ideals of honesty, value, and service to others. In short, educational experiences all the way through college should be directed not only toward developing a person's intellectual abilities, but also toward preparing him to be a free, decent, and responsible citizen in a democratic society—and thereby a socially adapted, happier individual.

Adolescence.—Adolescence, however, brings many new problems, among them, of course, sexual ones. The girl, if not given simple common-sense explanations about her feminine functions, may be frightened by menstruation or unprepared for sexual temptations, and so may acquire unfortunate attitudes that will endanger her future rôle as a wife and mother. The boy, if similarly unprepared, is especially apt to develop excessive fears as to the supposed consequences of certain almost universal outlets of his sexual energies—fears that may haunt him endlessly, yet that could have been prevented by kindly reassurance and advice.

But these are not the only problems of adolescence. Youngsters of this age may feel all sorts of impulsive idealisms, may become too highly competitive in sports and other pursuits, may show a premature resentment of authority, and yet take slights and minor failures very seriously. Parents and teachers must handle these intensities of feeling and emotional excesses with patience; they must maintain

the youngsters' loyalties, restore their self-confidence, reorient their social goals, reward good behavior adequately, and correct misconduct justly by small deprivations—but never with hatred, derision, or cruel punishment. In our adult sophistication, we often dismiss the adolescent's problems too lightly, and forget that this period may be one of intense striving, frustration, and deep unhappiness. And if we do not handle our youngsters well, many of them will continue to withdraw into unhealthy dreaming and self-isolation, or become brash, rebellious, and delinquent.

One other task remains for the parents even of the well-adjusted adolescent—that of helping him plan for an education and a career that is not only within his mental and physical capacities and suited to his individuality, but that is also economically feasible for the family. This takes sober judgment, unblinded by pride or false hopes, but failure in this may result in yet another youngster's becoming embittered for life because his parents pushed him into becoming a lawyer, a doctor, or an engineer when neither he nor they were equipped to realize such ambitions.

Marriage.—Marriage counseling is a large field in itself, but its main principles can, perhaps, be stated quite simply. First, marriage should be entered into not as an easily abandoned story-book adventure, but rather as a serious effort to find secure love, companionship, and contentment. But since nobody is really changed much by just saying, "I do," both partners must be prepared for a year or two of tolerant give-and-take while they change their impossibly romantic ideals, emancipate themselves emotionally from their respective families, and turn to each other for unselfish sharing, joint planning, and the cultivation of common interests and goals.

Until such relationships are established—and if religious issues are not involved—it may be best to postpone childbearing, since this rarely holds a bad marriage together, and in any case children deserve a happy and stable home. Sex adjustments in marriage are, of course, important, but have been much overemphasized by persons who try to blame all their troubles on their marital partners' unsatisfactory sex practices. Actually, if the couple can learn really to

like and to get along with each other, their sex relationships will in nearly all cases become satisfactory, too.

Social Life and Recreations.—No normal person can live happily in a social vacuum. Nor is it efficient for him to devote every ounce of energy to "getting ahead," since he'll probably get only a headache. For complete mental health, *social* play is necessary. This means not just crossword puzzles, movies, or lonesome reading, but also clubs, parties, and dances; not just setting-up exercises or solitary walks, but tennis, golf, picnics, sailing—whatever brings out the joy of living among friends. But one thing more: if a person's social pursuits are always accompanied by too much drinking, he'd better find out what's wrong either with him or with them.

The Veteran.—The problems of the war veteran during the next decade are going to be so important that they can't be overlooked even in the shortest talk. Many of the veterans will have been made impatient, cynical, restless, and short-tempered by their war experiences, and if they have further trouble in getting back to civilian life, many will also become embittered, demanding, and inclined to precipitate action. We must see to it that we welcome them back with real and not just vocal gratitude, that we respect their sensitivities, that we tide them over with occupational retraining programs and limited support, and then—most important of all—that we provide them with the jobs and the homes they want. But we must not, for their own sake, become sentimentally overindulgent, submit to organized pressure groups, or provide lifetime pensions for every claimed disability—because if we do, we are going to wreck more lives than have already been hurt by the war.

Middle Age and After.—Late middle age, too, is a difficult period—although not because, as some people superstitiously believe, "gland troubles" or "change of life" necessarily make it so. Rather it is a time of balancing life's accounts; a time when we must finally give up our youthful ambitions and admit our limitations or failures; a time when our children marry and leave us, to strike off for themselves, and when we may think that we have nothing to look forward to but a bleak and cheerless old age.

Many people don't take this gracefully. Men may clutch vainly for their youth by excessive work, strenuous sports, or extra-marital indulgences. Women, too, may start loveless "affairs" or run around to doctors complaining of all sorts of symptoms, but really trying to postpone their "menopause," as if this were the end of their careers.

Here, again, mental hygiene must be directed mainly toward cultivating more moderate habits and more sensible attitudes. The facts are that even the sexual function does not suddenly cease; instead, if it isn't pushed and overstrained, it may persist for many years. On the whole, as the old Greek philosophers taught, our later years can be a period of established skill and useful productivity, of social respect and prestige, and of calm, contemplative enjoyment of life. It is during this period that married couples should draw even closer together in their mature interests, their social and religious life, and in their pride in the emancipated lives of their children.

"Nervous Ill Health."—But events cannot always run smoothly, and every one must face difficult tasks, hard decisions, deep disappointments, and—yes, even injustice and adversity. A normal amount of anxiety in such circumstances is advantageous, since it makes us alert and mobilizes our energies to solve current problems. But if a person has developed unfortunate habits of being oversensitive, worrisome, moody, and easily discouraged, he may react to such stresses by becoming "nervous"—that is, irritable, unable to enjoy his work or play, sleepless, easily fatigued, and subject to various fears about his job, his family, and himself. At the same time, his physical health may suffer; he may develop headaches, or heart palpitations, or stomach disturbances, or bowel trouble, or all these symptoms and many more—and yet not recognize, or even deny, that his illnesses have anything to do with his nervous strain.

At this point just general advice such as can be given here is not enough; the person needs individual attention and help. Sometimes the sage counsel of a minister or of an old family friend will do, but if not, the nervous person should go to his doctor not only for physical treatment, but for guidance in solving his mental and emotional problems.

Unfortunately, too many people don't get at the real causes of their trouble in this way; instead, they read useless books on "how to relax," or go to untrained, self-styled "psychologists" or hypnotists, or try amateur "self-analysis," or keep taking drugs—some of them dangerous—as if any medicine could cure a worry or resolve an emotional conflict. And it is just as wasteful to shop from doctor to doctor looking for some physical disease that isn't there, instead of realizing that what is needed is less medicine and more mental peace.

General practitioners with the wisdom of experience can help most patients overcome mild neuroses if both patient and doctor recognize them as such; in fact it is only when the condition becomes chronic or severe that the patient need be sent to a psychiatrist. But even then it is no reflection whatever on the patient's "sanity"; the psychiatrist is consulted simply because he is a specialist trained in getting at the roots of the patient's dissatisfactions, giving him the self-understanding and advice he needs to straighten out his occupational, sexual, social, or other difficulties, and so helping him to regain his health and his peace of mind.

TYPES OF PSYCHIATRIC CASUALTY IN THE ARMED FORCES

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WORLD War I taught psychiatry two major lessons. First, it showed that the strains and stresses of the war experience, with its demands not only on the soldier, but also on the civilian population, did not result in an increase of the so-called major psychoses. Secondly, it greatly increased our insight into the origin and the psychology of certain neurotic conditions.

At the beginning of the first World War, authorities argued as to the nature of the traumatic neurosis, then usually called "shell shock." Some psychiatrists maintained that the neurotic symptoms—such as the paralysis of a limb without any organic findings—were due to very fine molecular changes in the brain, caused, for example, by the explosion of a shell nearby. In the course of time, however, agreement was reached that these neurotic symptoms were purely psychogenic in origin—*i.e.*, that they were nothing but the physical expression of certain psychological attitudes.

These lessons, gained more than twenty years ago, still seem to hold true and to be confirmed by the psychiatric experiences of World War II. But the whole situation, including the demands of army life, are much more complex in this war than in the previous struggle. There are many aspects of the present war situation—such as the very prolonged absence from home of soldiers living in desolate and secluded spots untouched by civilization—that were entirely absent during the first war and the psychological importance of which it is still hard to gauge.

Another fact has to be considered, also. In the period between the two world wars, psychiatry, which in 1914 still was in the stage of adolescence, has taken strides toward greater maturity. In particular, psychiatry during this period has become much more interested in the relationship between

personality make-up and the various types of mental condition. It has also learned about the interaction of environmental influence and personality reaction in producing abnormal mental attitudes. Psychiatric treatment, too, has had its most successful development during the past two decades. For these reasons, it may be expected that the experiences of this war will enrich our knowledge to no less an extent than those of the first World War.

That psychiatric disturbances in the armed forces present an outstanding practical problem, there can be no doubt. Estimates that so far have reached us—particularly from the English armed forces, which were in this war for a much longer time than our own—have set the ratio for psychiatric casualties at about one-third of all the casualties sustained.

Of all the problems involved, I can select only a few, and I shall choose those that I think are of greatest general medical importance. Although it also draws from current literature, my report is chiefly based on personal observations, particularly at the Research Service of the Worcester State Hospital, which began to concentrate on war psychiatry during the year after Pearl Harbor. Since then, patients transferred from the armed forces have, for shorter or longer periods of time, been studied at the research service, where their cases have been worked up not only from the psychiatric angle, but also from the social, the physiological, and other angles. In addition to this material, experiences with neurotic patients seen in the out-patient department of the Worcester City Hospital and with patients in my own private practice have been utilized.

Though one may more or less expect to find among soldiers discharged for psychiatric reasons all the clinical pictures mentioned in the psychiatric textbooks, with perhaps the exception of brain, sclerotic, and senile cases, there are two types of condition that, because of their relative frequency, demand our foremost attention. One of these is a major psychosis, schizophrenia, and the other a minor psychosis or neurosis.

What have we learned about schizophrenia or dementia præcox in the armed forces? This major psychosis, without any known organic pathology, usually befalls young people, and in addition to all other kinds of psychotic symptom

chiefly leads to withdrawal from reality, to disintegration of the entire personality, and more or less to a stage of emotional flatness—that is, to a general loss of vitality and of emotional life and ambition.

The majority of our study group, so far as they can be considered typical schizophrenics, were always—that is, long before their induction into the army—maladjusted persons. They showed a lack of ambition and an inability to maintain friendships and outside activities, often even in school life, and later on definitely failed in work adjustment, in social adjustment, and usually also in sexual adjustment.

In several of our cases, it became evident that certain symptoms of the psychosis had been present even before the patient was inducted into the army. In others, a stage of maladjustment had preceded the army period for a long time, and the patient could be considered as at least having been on the verge of a mental breakdown at the time of induction. In cases of the first type, the army, with its definite requirements and strict demands on the personality, only served to make the illness more conspicuous than it had been before. In the second type of case, it may have touched off the overt psychosis, which very probably would have developed sooner or later anyhow. In both cases, a more intensified screening-out process—including not only easily obtainable social data, such as previous state-hospital treatment, prison records, and so on, but also the patient's school and work records—would have prevented most of these men from being inducted into the army.

The clinical pictures and the uncertain prognosis of this group do not differ greatly from those of the schizophrenias in civilian life, and it was felt that in some cases the army situation had the importance at most of a precipitating factor. Soon after rearmament started, however, one not infrequently heard the opinion that there is a group of psychoses of a schizophrenic type that seem to be characteristic of the army. These psychoses differ from others by their good prognosis.

Among our group on the research service, there have been fifteen patients whom the above mentioned characteristics seem to fit quite well. In all of these cases, it could be seen that there was a great difference between their previous

personalities and adjustment and those in the larger group of average schizophrenias. Most of these patients had been quite extroverted and had shown good work and social adjustment before their army period. There were, however, certain personality traits that seemed to distinguish them from the average personality. They all seemed to have in common a certain lack of emotional maturity, and there were two further features that prevailed in this group. The one was a certain type of "softness," a lack of virility, and a greater dependence on others than the average person would be likely to show; the other was the trait of rigidity and constriction of the personality which made it difficult to adjust on a new level, in a new environment, and in as flexible a manner as is required for the varying situations of army life. Either unusual softness or unusual rigidity was present in all of these patients and in several both factors were combined.

Here, indeed, was it clear that the army situation had had a much greater importance in precipitating the psychosis than in the average clear-cut type of schizophrenia. In the majority of cases, it was quite evident that certain personality traits, such as softness and rigidity, interacted with the fundamentals of army life—its demand for toughness and adaptability and the roughness of its speech and play—fitting as a key would a lock.

In about half of the fifteen cases in this group, the psychosis had actually been preceded by a rather unusual situation of stress. In one case, a soldier from Massachusetts who had been trained in a Southern Army camp received the order for his transfer to Alaska just a few days before his marriage, which had been preceded by many years of engagement, was slated to take place. Another patient who, since his childhood, had had a physical handicap, a residual of poliomyelitis, had with much effort finally succeeded in joining the army; he was, however, soon again "left behind." Because of his inability to keep up with the others, he was placed on K.P. and latrine duty until he finally "blew up."

One significant finding of this study was that these so-called army schizophrenias, which among other things are characterized by their good prognosis, in their personality make-up and in their clinical pictures seem to resemble closely those cases of mental breakdown in civilian life that previously had

been considered as a separate benign group of schizophrenia-like psychoses. This kind of schizophrenia-like psychosis in civilian life also showed the outstanding importance of precipitating psychological factors, and it is, therefore, not surprising that in similar cases within the army group, the psychosis actually seems to have been precipitated by the army situation. In quite a few cases it was felt that probably the patient would not have become psychotic if he had not been inducted into the army. The difficulty is, however, that in these cases personality make-up and previous adjustment appear much more normal than in the more malignant type of schizophrenia; it is, therefore, doubtful whether even more elaborate screening would have prevented these boys' induction into the army.

Of greatest importance in these cases is adequate handling of the patient after his discharge from the army. To a certain extent, mere removal from the disturbing situation will help to restore the balance. However, the more active not only the psychiatric, but also the social-psychiatric approach to these patients is, the better, and the earlier restoration of health can be expected. The experiences in this hospital seemed to point very much in this direction, and rehabilitation of patients of this type will form an important future task.

Because of its still greater practical importance, I want to devote the rest of this paper to the question of the neurotic. The neurotic presents a problem that we have to face not only now, but probably even more in the future, in the aftermath of this war. Though a number of neurotic patients whose manifestations resembled one of the major psychoses also have been studied by the research service, neurotics are most apt to come to attention in a neuropsychiatric out-patient department.

Within a relatively short time, I have had an opportunity to examine and advise fifteen neurotic patients whose neuroses were considered as war neuroses since the men had seen military service and had been discharged from the armed forces because of nervous conditions. What are some of the high lights in these cases? In thirteen of the fifteen patients, the story showed that the man had been definitely of a nervous

and neurotic type long before induction into the army. In several cases, records of the out-patient department revealed that the patient had been seen there many years before his induction because of neurotic complaints without any organic basis.

All of these patients showed the typical make-up of the neurotic: they were oversensitive, preoccupied with themselves, bothered by feelings of inferiority, and given to reacting to difficulties with all kinds of nervous complaint. In other words, they were people who, in personality make-up and in ability to cope with the everyday problems of life, had always deviated considerably from the average. Several of them tended to cultivate their complaints and their introspective attitudes, thus showing an egocentric lack of a sense of proportion.

These patients present a great practical problem. Usually they come to the out-patient department with a diagnosis of neurosis, complaining that they are not able to work and to live a normal life. The majority have a rather querulous attitude and tend to stress that they have not been given the right chance in the army, that they have been worked too hard, and that their nervous condition is to be attributed to some incident in army life. There is not much sense in giving these patients a bromide prescription or another sedative. Even if this kind of symptomatic treatment should allay temporarily some of the nervous symptoms, it would not be able to alter the basic neurotic attitude and it would only prolong the feeling of illness and of need for treatment. In these cases, in which neurotic complaints continue even months after discharge from the army, there has already been established a fixation of the symptomatology for which the driving force is a strong urge toward self-defense.

What are the usual dynamics found in this group of neurotic patients? Without much interpretation, the following factors are recognized. First of all, there is the experience of failure, particularly of failure to succeed in the army. Next is a kind of compensatory reaction, a feeling of justification for being neurotic and unable to work and compete in civilian life, since the neurotic condition has been sanctioned by the army authorities, as indicated by the patient's having received

a medical discharge because of his nervous condition. At the same time, the army is being used as "scapegoat" because in the patient's opinion his condition has been more or less caused by the particular situation of army life. Furthermore, since he has officially been stamped as a neurotic, he is now very much inclined to use this fact for future self-defense. Having been an individual who always felt somewhat handicapped by his own make-up, and who, therefore, had difficulty in competing in civilian life, he is now unconsciously inclined to use the neurotic condition as a mechanism with which to evade the usual demands of life, such as building up a good existence, having a family, and so on.

What can be done to help this neurotic group find the way back from their neurotic fixation? They are the ones for whom the need for thorough rehabilitation work is and will be most urgent. And if they are not helped to solve the problems at the earliest possible moment, the danger is very great that they will continue to use their present fixations, and thus not only will remain ineffective, unsuccessful, and unhappy themselves, but also will become a permanent burden on the community, which will have to support them.

Several methods of approach have to be considered. First of all, it will be necessary to make a thorough investigation of the social situation of the patient to see how this can be best fitted to his present needs and how those factors which seem to impede his improvement and which tend to provoke his neurotic self-defense can be removed or remedied. At the same time, active and continued psychotherapy is the chief weapon with which the neurotic situation can be successfully attacked. And what is the general trend of this psychotherapy? In most cases there is neither need nor sense in going into any deep analytical searching away back to the patient's childhood. It will, however, be necessary to analyze in a careful way the present psychological situation of the patient in order to show him that every neurotic condition serves an unconscious purpose, that his present attempt to solve his problems is doomed to failure, and that there are other and more successful ways which are accessible to him.

He must be made to realize that even if he does achieve his goal of evading responsibility and of receiving security

through compensation, he will never be happy this way. If he retains his present attitude of disappointment and resentment, he alone will always be the one who really suffers, and he cannot expect real help from anybody else if he does not first himself adopt a constructive, positive attitude. Naturally one has to give the patient insight into the dynamics of his own case in a very diplomatic and tactful way, so as to make the positive solution palatable to him without increasing his feeling of failure and of loss of self-esteem. It goes without saying that encouragement will always have to be part of the general approach of the psychiatrist.

It should be mentioned that by far the majority of neurotics so far examined—and also of the previously discussed psychotic patients—had not seen any actual fighting. I should like to supplement this report, therefore, with a few remarks on neurotic conditions at the fighting fronts and their later development. The majority of patients who exhibit some kind of nervous condition under the stress of fighting, of prolonged shelling or bombing, have tended to show pictures resembling those of an anxiety neurosis—that is, in addition to general signs of nervousness, such as increased irritability, a worn-out feeling, and vague physical complaints, there are prolonged spells of anxiety accompanied by general shakiness. Second in number seem to be pictures of so-called conversion hysteria, such as the paralysis of one or more limbs, loss of voice, and so on, without any organic basis.

The experiences of this war have taught that it is highly important to attack these acute conditions as soon as possible after their occurrence. In most cases, the basic therapeutic régime consists of a rest period of at least forty-eight hours, with removal from the area of fighting if possible, and with the administration of a large amount of sedation which, through producing prolonged sleep, gives the organism a chance to recover from the acute shock and to blot out the traumatic experiences before they lead to the establishment of a kind of mental reflex pattern. In many cases, soldiers who suffered such an acute breakdown due to extraordinary stress could be sent back to the fighting lines after several days of rest. In other cases, this was not possible because

even after the above described treatment the patient continued to show neurotic symptoms and, therefore, eventually had to be discharged.

Certain studies have been made on a group of neurotic patients in the British armed forces [1] which seem to indicate that the difference in reaction to treatment is largely due to the type of original personality make-up. Among several features that were found in the group that did not react well to treatment may be mentioned a history of mental or neurotic disturbance in parent or sibling, an unsatisfactory work record, psychopathic traits, symptoms of present illness before army life, resentment of army life, and the onset of a neurotic condition without any serious exposure. These same features were more or less missing in the other group, which was really recovered and could again stand the stress of fighting.

In other words, it is conceivable that every man, whatever his make-up, may reach a point in actual combat, usually after prolonged stress, where his nerves give way and where he may temporarily show a neurotic condition. The more "normal" he originally was, however, the more chance there is that these symptoms will tend to disappear under adequate immediate treatment. The more he could be characterized as a nervous or neurotic person before the overt neurotic condition, the greater is the chance that his neurotic condition will resist treatment and will become fixed. And why? Because in his inherent nervousness, his unconscious desire to escape future strain and to solve his difficulties in a neurotic way will persist more than it would in a stronger personality make-up.

In the second, the not-recovered group of neurotics, more thorough screening probably could have prevented the induction of the soldier into the army. We may see here an interesting parallel to certain conclusions drawn from our discussion of schizophrenic soldier patients. The more "normal" a personality make-up is to start with, the more surely can the temporary breakdown be attributed to army life or to the fighting situation, and the better also is the prognosis.

[1] See "Neuroses in Soldiers: A Follow-up Study," by A. Lewis and E. Slater. *Lancet*, vol. 242, pp. 496–98, April 25, 1942.

There is one more therapeutic point that I want at least to mention because of its outstanding importance. That is the problem of compensation. In whatever way this question of compensation is solved in the after-war years, one point should be stressed. Compensation, if given at all to a neurotic, should be given in one lump sum rather than in continued installments. In the latter case, the unconscious desire to continue to receive the security of an annual payment must tend to fixate the neurotic attitude, since the patient knows that if he should lose his symptoms, he will lose the annual payment also. If this factor is not taken care of in a medically reasonable way, it will, therefore, tend to upset all the effects of treatment. For what good can be accomplished by psychotherapy, which tries to break through neurotic defenses, if the patient is vitally interested in the maintenance of his neurotic symptoms?

THE NEUROPSYCHIATRIC DISCHARGEE

A SAMPLE STUDY OF THE PRE-INDUCTION SCHOOL RECORDS AND POST-SERVICE RECORDS OF MEN DISCHARGED FROM THE ARMY BECAUSE OF NERVOUS OR MENTAL CONDITIONS

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THE percentage of men examined and found to be mentally or physically disqualified for military service in World War II has surprised and shocked the general public, since it had been assumed throughout the years that America is a nation of stalwarts. Among those rejected, the principal cause for disqualification has been for mental disease. Notwithstanding the fact that the rate of rejection for this cause has been higher than that for any other one reason, the principal cause for discharge from the army also is for nervous or mental reasons.

While as much study has been given to psychiatric procedures as to any of the examinations at induction stations, no procedure can be devised, in the selection of men for military service, that will guarantee satisfactory performance in all cases, even if more time were allowed for diagnosis. There are conditions in the pre-service lives of men that may never be discovered. There are weaknesses that may remain dormant until a man leaves his habitual environment and is subjected to rigorous training or to combat duty in a battle area. It is also probable that each person has a breaking point, and that any individual is liable to "combat fatigue" if subjected to an excessive and extended period of combat strain.

Men should not, therefore, be inducted for combat service if there is any doubt as to their emotional stability, because the dangers and problems that are inherent in such cases may result in disaster. If the soldier cannot become adjusted to the routine of training, he creates discord among his com-

panions, often seriously affecting the morale and *esprit de corps* of his unit. If he loses control of his faculties in a battle area, he becomes a danger to himself or to others, and may affect the success of a mission.

Thus, if it can be discovered at the time of examination for induction that a nervous or mental defect exists, the man should not be accepted, but should be permitted to remain at home to continue his customary civilian activities, and, if possible, to contribute to the war effort in this capacity. If allowed to do so, he usually can carry on.

This has been demonstrated by the fact that the majority of men who developed nervous or mental conditions while in service have regained their usual balance and have readjusted to a satisfactory civilian status after their discharge and return home. Of course, a mental defect may develop that cannot be corrected. If this happens, a man's usefulness is lost; he is no longer a contributing factor to society, and society must support him.

A more adequate screening process is possible through the use of information from medical, social, and educational histories. Consideration of such information would eliminate those men who are known to have been maladjusted in civilian society and who, therefore, are probably unfit for the rigors of military life.

In order to furnish such histories, the Selective Service System has recently initiated a plan called the "Medical Survey Program," which is designed to assist the armed forces in the difficult and exacting process of psychiatric diagnosis. There are three sources of information provided in the program: records from institutions as to commitment or treatment for nervous or mental defects; records from welfare agencies, or case-history studies as to social-medical conditions and work records; and records from educational institutions as to adjustment to school life and health while in school.

The Medical Survey Program is now functioning with varying degrees of emphasis. Every evidence is that when social, medical, and educational records are completed, they are extremely valuable as aids in the examination of registrants, to determine which should be accepted and which rejected.

Further, it is becoming evident that when all the sources of information concerning a registrant have been investigated and no deviation from the normal has been found, this fact may somewhat counterbalance the transient manifestations that the registrant presents during the hurried examination procedure.

This sample study of a group of dischargees was made to determine what evidence would have been available to assist in the pre-induction examination of these men if the Medical Survey Program had been in effect at the time of their induction. It was also an attempt to see how these dischargees have readjusted to vocations in civilian life. Facts about these dischargees are presented for the purpose of provoking questions. The implications and answers must be found elsewhere.

Sources of Information.—The names of the men discharged from the armed forces, for nervous or mental reasons, between December 7, 1941, and December 7, 1943, were obtained from the Selective Service local boards of a certain city.[1] There were 435 of these dischargees, distributed among the services as follows: the army, 349; the navy, 76; the Marine Corps, 9; the Coast Guard, 1.

Of the total, only three of the 349 discharged from the army had had less than 30 days of service; the navy dischargees showed 33 out of 76 with less than 30 days of service. The average length of military service was 170 days, if those with less than 30 days and one man with 10 years of service in the navy are excluded. The average age at the time of discharge was 23.7 years.

School Records.—Of the 349 army dischargees, 173 had last attended public schools in the selected city. Records on 133 of these were returned, but they were not complete in every case.

Fifty-five records showed only scholastic achievement, attendance, and degree of participation in athletics. Three men were shown as above average in scholarship; the remainder had either fair or poor scholastic averages. The attendance records of these 55 men were generally satisfactory. As to participation in athletics, none was shown to have par-

[1] Grateful acknowledgment is made here to the superintendent of schools and to the social-service groups of the selected city for their work on this study. There would have been no project without their coöperation.

ticipated to more than an average degree, and a fourth of them had not participated at all.

Thirty-two records had, in addition to the preceding information, a record of adjustment to classmates and to teachers, and of dependability. On these items alone there were very few data that showed maladjustment. The men had been accepted by their classmates and had usually been coöperative and dependable. Only two cases were marked "uncoöperative" and only three "unreliable."

On 27 records, personality characteristics were indicated by one or more of the following terms: "seclusive," "moody," "suspicious," "effeminate," "deceptive," "markedly nervous," "temper tantrums," "strikingly immature," "a show-off," "a daydreamer," and "peculiar."

Two of the 27 cases are selected at random to illustrate the information obtained from school records. To this information has been added the military and post-service vocational records.

School Record: Completed only the ninth grade, or freshman year of high school; he was then dismissed because of truancy, bad conduct, uncoöperativeness, and abusiveness to classmates. He was failing in all subjects and had reached the age of eighteen years, which was the legal age for compulsory attendance. Personality characteristics, as checked by his teachers, indicated that he was disliked by his classmates, was unreliable, deceptive, a show-off, and had temper tantrums.

Military Record: The dischargee was in the army 10 months. Prior to discharge for psychoneurosis, he was under the observation of the medical discharging board for 43 days. The board stated that his disqualifying disability was not incurred in service or aggravated by the same. He served only in the United States.

Post-Service Vocational Record: This man reported to the army classifier that he had earned $50.00 per week as a truck dispatcher prior to induction, but told the social-service interviewer that he had earned $65.00 per week prior to military service. At the time the survey was made, he was working for his former employer as a truck maintenance mechanic at $50.00 per week. He had filed a claim for disability compensation, giving his disability as stomach ailment. The case had not been adjudicated when this study was made.

School Record: Completed junior high school. His scholastic record was very poor; he was uncoöperative, disliked by his classmates, and unreliable. He was in chronic ill health, and was considered to be effeminate, deceptive, peculiar, and a show-off. He had been referred to a physician and a clinic, and the school health record showed a thyroid deficiency and 88 pounds overweight.

Military Record: In service 8 months; discharged for psychoneurosis, anxiety state, moderate, after 30 days' observation by the

medical discharging board. The board decided that his condition had existed prior to induction and had not been aggravated by active service.

Post-Service Vocational Record: This man reported to the army classifier that he had earned $50.00 per week as a milling-machine operator prior to induction. To the social-service interviewer, however, he reported that he had earned $1.13 per hour at this employment, which had been obtained through his high-school counselor. He had changed jobs frequently since his discharge, and was working for another employer on the same type of job at $.88 per hour. Claim for disability compensation had been disallowed by the Veterans Administration.

Of the remaining school records returned, 19 showed that the men had been referred to the schools' psychological clinic. Two of these cases are given with the military and post-service vocational records.

School Record: The record from the schools' psychological clinic indicated that this man had had two examinations. One, at the age of ten years showed a mental age of 7 years and an I.Q. of 71; the other, at the age of thirteen years, showed a mental age of 6 years and 3 months and an I.Q. of 65. He had been referred to the clinic because he was unable to keep up with the regular school work. After examination by the clinic, he was placed in a special class for the mentally retarded. His mother reported to the clinic that he had always been slow to learn, but liked to work and was willing; his father reported that the boy was not interested in school, but liked garden work.

Military Record: Length of service was 14 months. Discharged for psychoneurosis, conversional hysteria, manifested by severe headaches.

Post-Service Vocational Record: This man worked for his father as a painter both before and after military service. He was receiving medical attention to determine the cause of his headaches. He had not filed a claim for disability compensation.

School Record: The schools' psychological clinic had the following record on this dischargee: Two examinations. The first, at the age of twelve years, showed a mental age of 7 years and 2 months and an I.Q. of 61; the second, at the age of fifteen years, showed a mental age of 8 years and 4 months and an I.Q. of 60. The psychologist, after the first examination, reported: "Sluggishness, lack of effort; proper incentive might bring forth response. Glimmer of interest appears momentarily from time to time. Gait is awkward."

There was considerable follow-up by the clinic in this case. A visiting teacher reported that the mother had always worried about her son's getting into serious trouble because he had bad companions; that he had spent 29 days in jail because of a fight with a policeman; and that he had been in a C.C.C. Camp, but had stayed only a short time. The visiting teacher also reported that when he was eleven years old he had had an automobile accident, and his skull had been fractured. After this, he had had nocturnal spells which his mother called "cramps." These had occurred for only about two years. His parents had been advised by the psychological clinic to place him in an institution but had not done so.

Military Record: In service 18 months and was discharged because of undesirable habits and traits of character. He had not filed a claim for disability compensation.

Post-Service Vocational Record: This man was working irregularly as a laborer, but could earn $50.00 per week if he stayed on the job, as against the $20.00 per week that he had earned prior to induction. His poor work record was due to alcoholism.

Post-Service Vocational Records.—The administrative organization of the social-service agencies in the selected city volunteered to get into contact with the dischargees to determine how they had readjusted to civilian life, particularly as to their vocations. Eighty-six of the dischargees were interviewed. Reports on 20 others were made, all but three of whom were known to one or more social-service agencies. If there had been time to complete this phase of the study, all dischargees, except those who had left the city, could probably have been located and interviewed.

A comparison of pre-service with post-service vocational status showed that 23 of the dischargees who were interviewed had returned to the same employers, but seven of these had taken different jobs. Fifty-four had gone to work for new employers, 13 of these returning to the same type of job they had had prior to induction, while 41 not only had gone to work for new employers, but had taken different types of job from those they had had prior to their entrance into military service. Two had been in business for themselves before induction and had returned to these businesses.

As to methods of obtaining jobs, both pre-service and post-service, the data were as follows:

	Pre-service	*Post-service*
Personal application to new employer	37	31
Personal application to former employer	0	23
Private employment agency	1	2
United States Employment Service	1	3
Advertisement	2	2
Worked for father	1	1
Friend	17	9
Family	10	2
Union	4	0
Welfare agency	1	0
High school	3	0
Landlord	1	1
Civil service	1	0
Social-service agency	1	0
Employer came to man	0	1
Could not remember	2	0
Irregular jobs	0	2
Unemployed	2	7
Owned business	2	2

Post-service incomes as compared to pre-service incomes showed that 56 men were working at higher wages than had been earned prior to military service; 10 were working at lower wages; seven were unemployed; five were working for the same wages; and eight could not remember what they had earned prior to induction, and since being discharged had had irregular incomes because of absenteeism. The average weekly increase of post-service over pre-induction wages was $19.77. The greatest decrease in earnings was $36.00, in the case of a man who had earned $70.00 per week before his military service; however, the records on him were inconsistent. The greatest increase was $62.00 per week. This man had earned $18.00 per week before induction.

In this latter case, the dischargee's social adjustment in school had been quite satisfactory, with an average scholarship record. He had been out of school four years before being inducted. During three years of that time he had worked on a delivery truck for a department store as a "jumper" and "checker," which involved keeping records of materials. He had been in service seven and a half months and had been discharged because of dementia præcox, hebephrenia type. Two months after discharge he applied for disability compensation and obtained total disability, which was later reduced, due to the fact that he was employed full time. The plant where he obtained employment through the United States Employment Service manufactured parts for airplanes, and he was assigned with a group to train in the plant school. He became a jig repairman, earning $80.00 per week.

Reports on this man show that his readjustment to civilian life was progressing satisfactorily, with the man continuing to gain confidence in himself.

Of the 10 men who were earning lower wages than before they were inducted, eight had changed employers, two of these having the same type of job as before they entered service. The pre-service job of one of the latter had been irregular, but had carried a righ rate per hour. The pre-service wage of the other, as reported by the man himself, was $1.13 per hour, but this was not consistent with his past record.

Of the two men who had returned to the same employer, one reported to the social-service visitor that his pre-service

wage had been higher. His report to the army classifier, however, showed his pre-service wage to have been the same as the wage received in post-service employment. All the pre-induction records of these 10 men show erratic histories. The same is true for the seven men who were unemployed.

Experiences with the Same Employer.—Twenty-three men had returned to their previous employers. Of these 21 had had an increase in wages, six of them being on different jobs from those held before induction. Two showed the same wages.

Skills Learned in Service.—Sixteen men stated that they had learned a skill while in service that they had not had before. One such skill was described as "courtesy." Three of these men thought that their new skills had enabled them to obtain their present jobs. Seventy were of the opinion that they had not learned a new vocational skill while in the army.

Disability Compensation.—Twenty-five of the 86 men had filed claims for disability compensation with the Veterans Administration. Of the 13 adjudicated to date, six had been allowed and seven disallowed.

Records were found in the files of the social agencies on 17 of the 20 dischargees not personally interviewed. Six were reported upon after visits to their families: one had left home, seeking a change of climate, and his family was sending him money; two were reported to be working in other cities; two were in state institutions for the insane; one was in a veterans facility for mental cases. Of the 17 known to social agencies, all had some record of maladjustment prior to induction. No post-service vocational records were available on these men.

Attitude of Dischargees.—On the whole, the attitude of dischargees seemed satisfactory, but it was frequently found that the men resented having been discharged even when they understood that they could not become general-service soldiers. In such cases, they thought that the army should have found places where they could have been of some use or not have accepted them in the first place. A few resented their military experience, but these were usually men who had not wished to be inducted. Others were still trying to get back into service.

A very few thought that army service had aggravated their

conditions, and most of these did not seem to realize that their disabilities were nervous or mental, and referred to their discharges as being for physical reasons. One did admit that guns made him nervous. A few thought that the army or the government owed them a pension; all of these were found to have been known to one or more social-service agencies prior to their entrance into military service.

Some seemed particularly glad to be out of the army; these were men in homes where family conditions had always been effective in protecting them. Most of the others had a feeling of being "lost," since so many of their contemporaries were still in service; their intimate friends were gone. A few were pleased with their readjustment; these were the ones who were earning much higher wages than they had ever earned in their lives. Those who had been maladjusted in their civilian status prior to induction, particularly in the matter of occupation, were continuing to have trouble holding jobs and to be as out of step with life as they had always been. An interesting fact relative to the methods of obtaining jobs after leaving service was that not one man seemed to realize that his job status was protected under the Selective Training and Service Act, although in 23 cases the men returned to the employers for whom they had worked prior to induction.

Most of the men seemed to think that the regularity of the routine and training in the army had been beneficial. Of course, a few did not. In most cases the parents of the dischargees thought that the discipline had been good for their sons. As was to be expected, men with nervous or mental conditions did not usually have enough continuous service to have developed *esprit de corps* within a military unit, as most of these men had spent much of their service time in hospitals.

Contacts with Selective Service Local Boards after Separation from Service.—Only eight of the 133 dischargees had not reported to their local boards since leaving service; 14 had not reported to their boards until directed by the boards to do so; one had not reported until he had lost his discharge papers; two had reported only when they had tried to enlist, one of these after a quarrel with his wife; 61 had reported to their boards after discharge because they had received instruc-

tions to do so at the time of separation from service. Five of these 61 were keeping in close contact with their boards to report changes of address, and all these were men who had had contact with law-enforcement agencies.

Fifty-eight men indicated that they had not received any assistance from their local boards in obtaining reëmployment or new employment. Three of these stated that their contact with the boards had had something to do with employment, but that the local board did not make a contact with an employer for them. One man stated that he had reported to obtain assistance, but no indication was given that he had received it, since he had obtained his present job by "personal application."

One was accompanied to the board by his mother, to ask for assistance in obtaining a job. At the suggestion of the local-board clerk, he returned to the same employment he had had prior to his induction—*i.e.*, that of delivery boy for a printer. The social-service visitor reported that he had not returned to work after discharge until his mother took him to the board. One was asked by the board if he was returning to his pre-service job. He was and did. This man was a U. S. Post Office employee.[1]

Post-Service Advisement for Nervous and Mental Dischargees.—In not one instance was it found that any one, including the representatives of any agencies concerned with social-adjustment problems, had initiated a contact with a dischargee immediately after his return home, to offer guidance and assistance. It is understood that men now being discharged for nervous or mental reasons are being advised of agencies to which they may go for counsel after reaching home. This, however, does not seem to be sufficient. These men are not the ones who ordinarily have enough initiative to do what they should to help themselves, and they are the ones who particularly need guidance. What might be considered is a plan by which the proper community agency would be notified to get into contact with the neuropsychiatric

[1] This study was made before the Retraining and Reëmployment Administration issued its Order No. 1 of May 17, 1944; before the Servicemen's Readjustment Act of 1944 was approved on June 22, 1944; and before the Selective Service System issued its instruction, "Information Concerning the Veterans Assistance Program," on June 30, 1944.

dischargee to ascertain if he needs help, counsel, or rehabilitation. This type of service would not interfere with the functions of the veterans-service committees now being established in local communities. These dischargees are in a special category.

This sample study indicates that more facts about the prospective inductee are desirable if adequate psychiatric examinations are to be effected. This is necessary if the individual is to be treated justly, if the armed forces are to be protected, and if society is not to be burdened with problems that it might avoid.

Further knowledge is also needed about the problem of the readjustment of the veteran who has been discharged for nervous or mental reasons. From such knowledge might grow a coördinated effort, intelligently planned and locally operated, for the benefit both of the mentally unbalanced and of society.

ENLISTED MEN WITH OVERSEAS SERVICE DISCHARGED FROM THE ARMY BECAUSE OF PSYCHONEUROSES: A FOLLOW-UP STUDY*

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THE results of a follow-up study of the general adjustment of almost 6,000 enlisted men who had been discharged from the army for psychoneurosis have been reported elsewhere.[1] A large majority of the men included in that study had served only within the continental limits of the United States. Since many men are eliminated from the service or retained on duty in the United States because of psychoneuroses that become manifest during training or prior to shipment overseas, it is probable that in general the soldiers

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[1] See "Enlisted Men Discharged from the Army Because of Psychoneuroses," by Norman Q. Brill, Mildred C. Tate, and William C. Menninger. *Journal of the American Medical Association*, Vol. 128, pp. 633–37, June 30, 1945.

who were sent overseas constituted a more stable group than those who did not serve overseas.

This study is concerned with an analysis of the special characteristics of the group that had had overseas service (hereafter referred to as Group B), and with a comparison of this group with the unselected group previously reported (hereafter referred to as Group A).

Method.—Originally, a random selection of men discharged from the army during the eight-month period between May 1, 1943, and January 1, 1944, was made on the basis of serial numbers. All of the men had been out of the service at least six months. Approximately 7,000 names were selected. Basic data used in this study were obtained from the Medical Statistics Division of the Surgeon General's Office and from the Demobilized Records Branch, of the Adjutant General's Office. In only 5,937 cases was sufficient information available to warrant inclusion in the study.

A questionnaire to be mailed was drawn up with the assistance of the Morale Services Division.[1] In order to determine whether or not the presence of an individual's name on the questionnaire would in any way influence the validity of his replies, a preliminary sampling of 500 was undertaken. In half of these the individual's name appeared on the questionnaire and in the other half no identification was included. In the latter group, in order to determine whether anonymity was preferred, a note was added stating that it was not necessary to sign one's name.

Assurance was given that replies would remain confidential and that the information would not be transmitted to any other government agency or be used in the veteran's further relations with the army. It was realized from the start that the replies would represent subjective impressions, perhaps colored by many motives, and that they would not be completely objective. However, with recognition of the limitations in the reliability of the responses obtained in this manner, it was believed to be important to determine at least what the veterans would say about themselves.

Replies to this pre-testing showed that approximately one-

[1] Now, The Information and Education Division, Army Service Forces Headquarters.

half of those who were given the opportunity to remain anonymous chose to identify themselves, and that there was no qualitative or quantitative difference in the replies from the main group as compared with the anonymous group.

Five thousand, nine hundred, and thirty-seven questionnaires with the individual's name on them were mailed to enlisted men discharged from the army on Certificates of Disability with a diagnosis of psychoneurosis. Replies were received from 4,178—over 70 per cent of the total.

Since it was possible that the 30 per cent of those who did not reply might differ from the others in the matters of health and employment and, therefore, affect the reliability of the findings, a personal follow-up on a sampling of two hundred of this group was undertaken with the assistance of the Home Service of the American Red Cross. Replies obtained in this fashion were essentially the same as those in the large group. Out of this large unselected group (Group A) were selected those who had had overseas service (Group B). Group B consisted of 536 men, or 13.7 per cent of Group A.

Results of Study of Unselected Group (Group A).—The findings of the previous report had indicated that men discharged from the army because of psychoneurosis differ significantly from the army average in age, education, and army grade. In general these men consider their health to have been adversely affected by their army service. They believe themselves to be in poorer health than they were at induction. This health impairment is described chiefly in terms of physical disease and, in general, the veterans do not recognize the psychological aspects. It was found that the longer a man in this group served in the army, the more likely he is to consider his health to have been affected adversely. Men with overseas service were found generally to consider themselves to be sicker than those whose total service was in this country. Need was expressed for medical and hospital care out of proportion to their pre-army requirements.

Definite changes in employment were noted. More men were unemployed than at the time of induction. The unemployed group, for the most part, was found to be composed of those who had been working before induction. Frequently

poor health was given as a reason for failure to work full time. There was no indication that as a group these men were discriminated against because they had received medical discharges.

Basic Data from the Group with Overseas Service

Age.—The age distribution of Group B (the overseas veterans) is shown in Table I. Comparison with the percentages

Table I.—Age Distribution* of Men with Overseas Service Discharged from Army for Psychoneuroses (Group B) as Compared with Unselected Group Discharged for Psychoneuroses (Group A) and with Total Army Population, in Percentages

Age	*Group A*	*Group B*	*Total army population*
Under 20 years	7.9	0.9	11.5
20-24 years	32.6	33.8	41.9
25-29 years	25.7	37.0	25 5
30-34 years	20.6	16.6	13.5
35 years and over	13.2	11.7	7.6
	100.0	100.0	100.0

* For this and subsequent tables the "unknown group" for which data were inadequate was assumed to be distributed in the same proportion as those for which data were obtained.

for Group A and for the army population as a whole indicates that the men in Group B tend to be older. Whereas 46.6 per cent of the general army population were twenty-five years of age or older upon entering the service, the corresponding figure for Group A was 59.5 per cent and for Group B 65.3 per cent.

Marital Status.—There was no pronounced difference in the marital status of Group A as compared with the total army population. The men with overseas service, however, present a different picture. (See Table II.) While 63.4 per cent in Group A were single, as compared with 59.9 per cent in the total army population, for the overseas sample this percentage was 82.6. The difference is also reflected in the percentages of men who were married. Only 12.7 per cent in the overseas sample were married as compared with 31.2 per cent in Group A and 38.0 per cent in the total army population. There has been no selection of men for overseas

TABLE II.—MARITAL STATUS OF MEN WITH OVERSEAS SERVICE DISCHARGED FROM ARMY FOR PSYCHONEUROSES (GROUP B) AS COMPARED WITH UNSELECTED GROUP DISCHARGED FOR PSYCHONEUROSES (GROUP A) AND WITH TOTAL ARMY POPULATION, IN PERCENTAGES

Marital status	*Group A*	*Group B*	*Total army population*
Single	63.4	82.6	59.9
Married	31.2	12.7	38.0
Separated	0.5	1.5	0.5
Divorced	2.5	2.8	1.4
Widowed	2.4	0.4	0.2
Total	100.0	100.0	100.0

service based on marital status that would account for such wide variations.

Education.—In the original study it was found that the psychoneurotic dischargees (Group A) had a lower educational achievement than the army as a whole. Examination of the data for the men who had overseas service indicates an even more impressive difference. (See Table III.) In

TABLE III.—EDUCATION OF MEN WITH OVERSEAS SERVICE DISCHARGED FROM ARMY FOR PSYCHONEUROSES (GROUP B) AS COMPARED WITH UNSELECTED GROUP DISCHARGED FOR PSYCHONEUROSES (GROUP A) AND WITH TOTAL ARMY POPULATION, IN PERCENTAGES

Education	*Group A*	*Group B*	*Total army population*
Elementary school only (Grades 1-8)	43.4	48.9	30.9
High school (1 to 4 years)	45.1	45.7	53.2
College (including postgraduate work for 1 year or more)	11.5	5.4	15.9
Total	100.0	100.0	100.0

the latter (Group B), only 5.4 per cent had had education beyond high school, whereas 11.5 per cent in Group A and 15.9 per cent in the total army population had had some college work. For 48.9 per cent in the overseas sample, education had been limited to elementary school. This compares unfavorably with the 43.4 per cent in Group A and the 30.9 per cent in the total army. These differences cannot be accounted for on the basis of age alone.

Army Grade.—The army-grade distribution of the over-

seas group more closely approximated that for the entire army than did the corresponding figures for Group A. (See Table IV.) This finding was to be expected in view of the longer period of service of the overseas group.

TABLE IV.—GRADE OF MEN WITH OVERSEAS SERVICE DISCHARGED FROM ARMY FOR PSYCHONEUROSES (GROUP B) AS COMPARED WITH UNSELECTED GROUP DISCHARGED FOR PSYCHONEUROSES (GROUP A) AND WITH TOTAL ARMY POPULATION, IN PERCENTAGES

Army grade	*Group A*	*Group B*	*Total army population*
Private (including aviation cadet)	70.2	51.7	40.2
Private, first class	13.9	21.3	21.0
Corporal (including technician, fifth class)	9.0	12.1	18.3
Sergeant (all grades)	6.9	14.9	20.5
Total	100.0	100.0	100.0

Diagnosis.—In the original study (of Group A) almost 75.0 per cent had been diagnosed anxiety state, conversion hysteria, or mixed type of psychoneurosis. The total of these three diagnostic groups in the present study is 82.2 per cent. All other types continued to be relatively infrequent in incidence. (See Table V.)

TABLE V.—DIAGNOSIS OF MEN WITH OVERSEAS SERVICE DISCHARGED FROM ARMY FOR PSYCHONEUROSES (GROUP B) AS COMPARED WITH UNSELECTED GROUP DISCHARGED FOR PSYCHONEUROSES (GROUP A), IN PERCENTAGES

Diagnosis	*Group A*	*Group B*
Mixed type	26.6	33.7
Anxiety state	24.6	36.8
Conversion hysteria	20.8	11.7
Hypochondriasis	7.0	3.8
Neurasthenia	6.1	2.0
Anxiety hysteria	2.9	2.9
Reactive depression	1.2	0.9
Neurosis (somatic)	1.0	*
Obsessive compulsive	0.6	*
Neurocirculatory asthenia	0.5	*
Unclassified	8.7	7.6
Total	100.0	100.0

* Less than .5 per cent.

Incidence of Disciplinary Problems.—There was no record of trial by court-martial in 85.6 per cent of the men included in Group B. (See Table VI.) This is lower than the 92.4

TABLE VI.—FREQUENCY OF COURTS-MARTIAL AMONG MEN WITH OVERSEAS SERVICE DISCHARGED FROM THE ARMY FOR PSYCHONEUROSES (GROUP B) AS COMPARED WITH UNSELECTED GROUP DISCHARGED FOR PSYCHONEUROSES (GROUP A), IN PERCENTAGES

Recorded courts-martial	*Group A*	*Group B*
None	92.4	85.6
One	5.6	9.7
Two	1.3	2.8
Three or more	0.7	1.9
Total	100.0	100.0

per cent reported in Group A, but the difference is not great enough to indicate that the psychoneurotic soldier in Group B constitutes a significant disciplinary problem. The longer period of service could be expected to account for a considerable amount of the increase in incidence of courts-martial in the overseas group.

Summary.—Basic data for a series of 536 enlisted men who served outside the United States and were discharged from the army for psychoneuroses were compared with similar data for a series of almost 6,000 enlisted men discharged for the same reason who were unselected for place of service (Group A), and then with over-all army averages. These comparisons revealed the following differences:

1. The men in Group B (with overseas experience) are in general older.
2. They are much more apt to be unmarried.
3. They have had less schooling.
4. They show a greater frequency of uncomplicated anxiety states and less conversion hysteria.
5. They have a higher court-martial rate.
6. Their army-grade distribution more closely approximates that of the entire army than that of the unselected Group A.

Findings of the Follow-up Study

The data on health and employment revealed by the follow-up study were as follows:

Health Before Induction.—Of Group B, 80.4 per cent considered themselves to have been in good health before induction. In this same group, 17.4 per cent considered that their health had been fair before induction and 2.2 per cent felt that their health could best be described as poor.

Current Health.—In classifying their current health status, only 2.6 per cent of these discharges (Group B) considered themselves in good health and 42.7 per cent considered their health to be fair. Over half, or 54.7 per cent, considered their current health to be poor.

Comparison of Estimates of Health for the Two Groups Studied.—There is an impressive difference in the estimates of health before induction in the two groups, A and B. Eighty per cent of the men with overseas service reported their pre-army health as good; in contrast to this, 48.8 per cent of the men in Group A believed that their health had been good before army service.

Both groups reported a high incidence of deterioration of health. But, whereas only 69.1 per cent of the "domestic service only" men described their current health as being worse than their health at induction, 91.9 per cent of those with overseas service reported their current health as worse. Of the 91.9 per cent of the overseas group who reported deterioration in their health while they were in the service, 24.7 per cent considered their health to have deteriorated further since discharge. The remainder described either no change (63.9 per cent) or improvement, (11.4 per cent).

Medical Care and Hospitalization.—Confirmation of the high level of pre-induction health for the men in Group B is found in their answers to a question about the extent of doctor's care necessary before entrance to the army. Only 5.4 per cent had been seeing doctors "fairly often"; 23.8 per cent had seen doctors "seldom," and 70.8 per cent "not at all." In Group A, 15.3 per cent had been seeing doctors "fairly often"; 37.9 per cent "seldom"; and 46.8 per cent "not at all."

The increased need for medical care since discharge from

the army that was pointed out in the earlier report[1] is also apparent for Group B. Twenty-four per cent reported at least one hospitalization since discharge. This is higher than the corresponding figure of 14.6 per cent for Group A. Most (three-quarters) of these men had been hospitalized only once; a few had been hospitalized eight or nine times. In many instances hospitalization involved no more than remaining in the hospital overnight for tests.

For Group A, the period between discharge and first hospitalization varied from less than one month to nine months or more, with a median of 3.2 months. For Group B, the range was approximately the same, but with a median of 2.8 months.

With regard to employment, the findings were as follows:

Present Employment Compared with Pre-induction Employment.—Although most of the men discharged from the army for psychoneurosis in Group B are currently employed, there is a decrease of employment over the pre-induction status. Before army service, 94.9 per cent of this group were working. Since discharge, 77.7 per cent have been working. Before induction, 3.2 per cent had been unemployed and since discharge unemployment among these veterans has increased to 21.2 per cent. (See Table VII.)

TABLE VII.—PRE-INDUCTION EMPLOYMENT AS COMPARED WITH PRESENT EMPLOYMENT OF MEN WITH OVERSEAS SERVICE DISCHARGED FROM THE ARMY FOR PSYCHONEUROSES

	Before induction	*Since discharge*
Per cent employed	94.9	77.7 *
Per cent unemployed	3.2	21.2
Per cent students	1.9	1.1

* Two-thirds full time; one-third part time.

Pre-induction Occupation Compared with Present Occupation.—Arbitrary categories of employment were set up in order to study the occupational stability of the veterans in Group B. The trend seen in this group was the same as that in the original study. In both it was noticed that there had been a decrease in laborer, farmer, craftsmen and service-

1 *Op. cit.*

worker groups, and an increase in the operative [1] and clerical groups. The increases in these latter categories are significant since they represent actual numerical increases in the face of a marked rise in the unemployed figure. Out of the total group, 33.3 per cent returned to the same kind of job after separation from the army (See Tables VIII. and IX.)

TABLE VIII.—PRE-INDUCTION OCCUPATIONS AS COMPARED WITH PRESENT OCCUPATIONS OF MEN WITH SERVICE OVERSEAS DISCHARGED FROM THE ARMY FOR PSYCHONEUROSES

	Pre-induction		*Present*	
Occupation	Number	Per cent	Number	Per cent
Operatives	159	30.2	170	32.4
Laborers	88	16.6	40	7.9
Farmers and farm laborers	90	17.2	62	11.6
Craftsmen	70	13.2	53	9.7
Clerical workers	31	5.8	41	7.9
Salesmen	19	3.6	13	2.4
Service workers	17	3.2	7	1.3
Business owners and managers	13	2.3	13	2.4
Professional and semi-professional workers	15	2.8	11	2.1
Students	10	1.9	6	1.1
Unemployed	17	3.2	113	21.2
Total	529	100.0	529	100.0

The Unemployed.—As in the previous report, it was found that most of the unemployed veterans had been working prior to entry into the service. Only one out of 20 of those in Group B who are now unemployed had been unemployed before induction. The distribution of the present employed and unemployed groups as compared with their pre-induction status is presented in Table X.

The veterans with overseas service (Group B) gave a variety of reasons for their failure to work. The majority (77 per cent) attributed their unemployment to poor health, which in most instances was described as a purely physical limitation. Only a minority appeared to recognize the psychological nature of their illnesses. External conditions such as "temporary shut-down of the shop for re-tooling," and shortage of work in a highly skilled and specialized job, were

[1] This category, as defined by Selective Service and the War Department, includes workers, usually in industrial plants, who can be hired and taught their tasks in a relatively short time. Their tasks usually are the operation of various types of automatic machine.

TABLE IX.—PRE-INDUCTION OCCUPATION AS COMPARED WITH PRESENT OCCUPATION OF MEN WITH OVERSEAS SERVICE DISCHARGED FROM THE ARMY FOR PSYCHONEUROSES, SHOWING OCCUPATIONAL SHIFTS *

	Present occupation											
Pre-induction occupation	Operatives	Laborers	Farmers and farm laborers	Craftsmen	Clerical workers	Salesmen	Service workers	Business owners	Professional and semi-professional workers	Students	Unemployed	*Total*
Operatives	*75*	13	9	14	10	4	1	3	...	1	29	159
Laborers	30	*9*	10	5	6	1	...	...	1	2	24	88
Farmers, farm laborers	24	4	*36*	7	...	...	...	...	1	...	18	90
Craftsmen	15	5	6	*21*	...	...	2	2	1	...	18	70
Clerical	3	2	...	...	*17*	2	...	1	...	...	6	31
Salesmen	4	1	...	1	3	*4*	...	...	2	2	2	19
Service workers	8	1	...	...	1	...	*4*	...	...	...	3	17
Business owners and managers	1	1	...	1	1	1	...	*4*	1	...	3	13
Professional and semi-professional	4	1	...	1	1	1	...	...	*4*	1	2	15
Students	2	1	...	...	1	...	...	3	1	...	2	10
Unemployed	4	2	1	3	1	...	...	...	...	...	*6*	17
	170	40	62	53	41	13	7	13	11	6	113	529

* The italicized figures indicate the numbers remaining within the same occupational categories—a total of 180, or 33.3 per cent.

TABLE X.—PRE-INDUCTION AS COMPARED WITH PRESENT EMPLOYMENT DISTRIBUTION OF MEN WITH OVERSEAS SERVICE DISCHARGED FROM THE ARMY FOR PSYCHONEUROSES

Status before induction	*Present status* Per cent employed *	Per cent unemployed	Total
Per cent employed *	77	20	97
Per cent unemployed	2	1	3
Total	79	21	100

* Includes students.

among the reasons given by the 23 per cent who reported conditions other than health for their failure to work. These figures do not differ significantly from those of Group A.

Source of Help in Finding Employment.—Only 17.7 per cent of the men discharged from the army for psychoneuroses after overseas service have returned to their old jobs. Forty-seven and two-tenths per cent reported that they had found new jobs without help, and 5.6 per cent had been helped by friends and relatives. Federal agencies had assisted 14 per cent to find jobs, and 2.6 per cent reported help from sources such as voluntary community groups, unions, and fraternal organizations.

Considerable differences are noted when these findings are compared with those for Group A. Proportionately, almost twice as many men in Group A returned to their old jobs, and correspondingly few of them sought assistance in finding new jobs. (See Table XI.)

Attitude of Prospective Employers as Reported by Veterans.—Of the overseas veterans currently employed, 74.1 per cent reported no difficulty in getting jobs, despite the fact that they had received medical discharges. Of the 25.9 per cent who felt that the prospective employer showed some reluctance to hire them, approximately half reported "failure to pass the physical examination" as the reason for the reluctance. Comparison of these figures with those for Group A shows a marked similarity, with 73.5 per cent of Group A reporting no difficulty in getting jobs and 22.7 per cent feel-

ing that there was some reluctance on the part of employers to give them jobs. (See Table XII.)

TABLE XI.—SOURCES OF HELP IN FINDING EMPLOYMENT REPORTED BY MEN WITH OVERSEAS SERVICE DISCHARGED FROM THE ARMY FOR PSYCHONEUROSES (GROUP B) AS COMPARED WITH UNSELECTED GROUP DISCHARGED FOR PSYCHONEUROSES (GROUP A), IN PERCENTAGES

Source of help reported	*Group B*		*Group A*	
Returned to old job		17.7		33.0
Secured new job:				
No help	47.2		41.6	
United States Employment Service	11.2		8.6	
Veterans Administration	1.5		0.6	
Selective Service	1.3		0.7	
American Red Cross	0.9		0.6	
Friends or relatives	5.6		6.1	
Other sources	1.7		1.8	
	—	69.4	—	60.0
Unemployed		12.9 *		7.0
Total		100.0		100.0

* This figure differs from the figure for those reporting current unemployment shown in Table X (21 per cent). While only 77 of the group are now working, 87.1 per cent have worked at one time or another since discharge.

TABLE XII.—ATTITUDES OF PROSPECTIVE EMPLOYERS REPORTED BY MEN WITH OVERSEAS SERVICE DISCHARGED FROM THE ARMY FOR PSYCHONEUROSES (GROUP B) AS COMPARED WITH UNSELECTED GROUP DISCHARGED FOR PSYCHONEUROSES (GROUP A), IN PERCENTAGES

Attitude of prospective employers reported	*By employed*		*By unemployed*	
	Group B	Group A	Group B	Group A
Employer showed no reluctance to hire	74.1	73.5	60.6	59.7
Employer reluctant to hire:				
Failed to pass physical examination	13.5	12.4	19.2	16.2
Physical risk for industrial insurance	3.7	2.7	7.7	4.6
Too "nervous"	5.0	2.3	4.8	4.4
Uninterested because of medical discharge	2.0	2.9	1.9	3.6
Limitations of work a factor	0.2	0.5	1.0	0.7
No details	1.5	1.9	4.8	3.0
	25.9	22.7	39.4	32.5
Total	100.0	100.0	100.0	100.0

Among the veterans in Group B, currently unemployed, 60.6 per cent believed that there was no reluctance on the part of employers to offer jobs, while 39.4 per cent did feel that their employment prospects were limited, for one of several reasons associated with their impaired health. As one might expect, this is a higher percentage than is found in the employed group. These findings are not remarkably different from those of Group A, of whom 59.7 per cent reported no reluctance on the part of employers, while 32.5 per cent believed that their medical discharges or ill health contributed to their failure to obtain jobs.

Summary and Conclusions

The man who has served overseas and who has been discharged from the army because of a psychoneurotic disorder is apt to be older and less well educated than the average man in the army, and he is more apt to be single. These trends, which had been observed previously in a much larger sample of men, who for the most part had not seen service outside the continental limits of the United States, were more pronounced in the overseas group. This suggests that the combination of lack of education, increased age, and failure to marry is associated with decreased stability and adjustability. It in part refutes the theory that the married man, because of separation from his family, is less apt to adjust satisfactorily in the army. It is possible that the individual with more education has a better grasp of the issues at stake in the war and that, as a result of better motivation, he is less apt to develop an incapacitating psychoneurosis.

The vast majority—80 per cent—of the men included in this study stated that their health was good prior to entering the army. However, 91.9 per cent reported deterioration in their health during—and presumably attributed to—their period of army service. Since 69 per cent of those who had never served overseas and had been discharged for psychoneurosis report similar deterioration in their health, the stress of overseas service can by no means be considered the sole factor contributing to the high incidence of change in health status reported by the overseas group.

Since psychoneurotic disorders occur in response to the

varying stresses of military service, it has not uncommonly been assumed that improvement or recovery will occur in many after return to civilian life. Actually, this was not found in the present group studied. Only 11.4 per cent reported improvement since discharge from the service, in contrast to 63.9 per cent who reported no change and 24.7 per cent who reported further deterioration in their health since returning to civilian life.

The change in the health status of the men since induction is reflected in the increased need for medical care. Of the overseas group, 24 per cent had been hospitalized one or more times since discharge. In many instances, however, hospitalization had involved merely examination and testing. The fact that almost three-quarters of the men had not been receiving any medical attention prior to induction makes the figures particularly significant.

Unemployment has increased from 3.2 per cent to 21.2 per cent. Approximately three-fourths of the men are working, but one-third of these only part time. The overseas group in this respect has made a poorer adjustment than those whose service was confined to the states. The majority of the men who are unemployed attribute their failure to work to poor health. It would appear from the replies received from the men that for the most part they do not recognize the psychological nature of their illnesses, although in this regard they do better than men without overseas duty. They generally describe their conditions in terms of physical limitations.

Occupational shifts such as have been observed after previous wars are apparent in the present group. The demand for operatives and clerks during war-time expansion of industry is reflected in the numerical increases in these categories. The trend away from the laboring and farmering occupations usually reverses in the post-war period. It is significant, however, that only one-third of the group returned to the same kind of job after separation from the army.

Most men secured new jobs or returned to their old jobs without the help of agencies set up to assist them. As more men return to civilian life and as jobs become more scarce

and more difficult to get, increasing use will probably be made of these agencies.

Only 39.4 per cent of those who are unemployed felt that they had difficulty in getting jobs because of their medical discharges. The majority of unemployed, then, appear not to have sought jobs because of the state of their health, or to have been unsuccessful in getting jobs for reasons other than poor health. When one considers that almost 26 per cent of those who are employed reported that they encountered reluctance on the part of employers to hire them because they were "not well enough" or because they had received medical discharges, it would appear that, at least for the present, a medical discharge for psychoneurosis in itself is no great obstacle in the way of getting a job.

The limitations of the method used in obtaining the data were pointed out in the report of findings in Group A. Exaggerations may have been made, consciously or unconsciously, for many reasons. It was also realized that it is relatively easy to obtain a job at present.

This study does, however, indicate that there is a potentially large war-induced or war-aggravated psychiatric problem that will require a solution. So far, it appears that spontaneous improvement in the psychoneurotic cannot be expected after return to civilian life. This may be the result of the need for face-saving illness while the war is still on; many, too, believe that other factors involving secondary gains of illness, such as pensions, are in part responsible. Careful investigation of the problem by civilian psychiatrists is urgently needed if the proper solution is to be found.

BOOK REVIEWS

THE PEOPLE'S CHOICE—HOW THE VOTER MAKES UP HIS MIND IN A PRESIDENTIAL CAMPAIGN. By Paul F. Lazarsfeld, Bernard Berelson, and Hazel Gaudet. New York: Duell, Sloan, and Pearce, 1944. 178 p.

"This is a report on modern American political behavior," and because national elections are grandiose adventures in changing the attitudes and convictions of others, and the results are measured with stark, frightening simplicity, the matter is of real importance to every one whose business is people.

The developing convictions of 3,000 persons were watched and (the name of the senior author would have assured this anyway) every safeguard was placed about the validity of the findings and every effort made to see that the process of study did not itself influence the vote. The county studied is typical—has voted as the country did for forty years; the sample is typical (such a book is always good reading if only for the ingenuity of its techniques); and the results are clearly enough defined to demand acceptance.

The national election of 1940 was the subject, the study starting in May and ending after the election. This allowed soundings before anything much had started (basic predilections), after the conventions, after the acceptances, during the heat of the campaign, and at the time of vote. The kinds of people who voted in a certain way; those who changed and in what way and why; the value of various kinds of argument; and particularly the means of communication used (*e.g.*, radio, newspaper, magazine, personal contact)—these are carefully and clearly covered.

The book contains a staggering amount of data and suggested meanings—in fact, too much; sociologists as well as psychiatrists need to learn from the housewife that you don't get clear jelly if you squeeze the fruit. And if I advise you to read the volume, it is with the full realization that it will be many years before we can integrate this immense and insistent effort at manipulation into the therapeutic job of each office day. You will gaily nod your agreement with the exciting proof that "electioneering" almost entirely reaffirms, or brings to light, or crystallizes what the person had originally been predisposed to register. And you will gravely wonder over the equally valid exhibit that those who are most uncertain are the ones who least listen to the radio, least read the papers, show the least interest.

The authors began with the usually accepted S.E.S. (socio-economic status) ratings. To this they added the factors of religion and residence (urban or rural). This total determined the "Index of Political Predisposition"—the I.P.P. A wealthy Protestant farmer got an I.P.P. of 1; a Catholic on the lowest S.E.S. level living in the city, one of 7. The former had an overwhelming Republican, the latter an overwhelming Democratic predisposition. In spite of all the fuss, the final vote very closely followed the I.P.P.

There are innumerable summarizing tables covering the factors of interest, of exposure to propaganda, of the effect of conflicts within I.P.P., and so on—and there are more to come in a larger volume. Personal persuasion can produce some change, but in major part a political campaign makes the voter aware of his I.P.P. and crystallizes this awareness in his vote. (This does not explain why the country ever voted Republican. The authors have not sufficiently stressed the possibility that prior to 1930 the S.E.S. was built on the socio-economic class with which the voter identified himself, whereas since then it has been rather the actual S.E.S. that is important.)

The conception of the plan, its execution, its resourceful little ways of surmounting difficulties, its quite inescapable indications of the way the wind blows in these matters—all this makes it excellent (I would think, prescribed) reading. I must admit that Lazarsfeld has at other times shown us exciting forests not quite so thickly grown.

But even if you get lost, each tree is quite worth your interest.

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EMOTIONAL FACTORS IN LEARNING. By Lois Barclay Murphy and Henry Ladd. New York: Columbia University Press, 1944. 404 pp.

This is an attempt at summarizing and integrating the results of a special study of individual students at Sarah Lawrence College. The work was begun by Henry Ladd, but was interrupted by his death in 1941. The records that he left were taken over by Dr. Murphy, who, at the same time, had been making a special study of the students in two entering freshman classes. The present volume represents a synthesis of the two investigations.

The book is divided into two parts. Part I, entitled *The Development of an Educational Point of View*, consists of a preface and twelve chapters by Dr. Murphy, which bear such titles as *Individual*

Education and Social Change, Interests and Motivation, and *Insecurity at the College Level.* These chapters contain many sound bits of educational wisdom. It is pointed out, for example, that the soundest way of helping students to solve the personal difficulties from which few, if any, are free is not always through direct attack on the problem itself. Often, a more wholesome and lasting solution may be reached through the provision of an educational regimen that is both stimulating and engrossing, by means of which the student may by-pass his difficulties and find a new route to satisfaction.

With this principle in mind, Dr. Murphy places much stress upon the importance of providing courses with genuine content—something that the student can "put his teeth into"—and of requiring from each one the highest level of performance of which he personally is capable. Such a program, it is repeatedly pointed out, demands not only an intimate knowledge of the individual talents and limitations of every student, but also close and continued observation of the progress made by each toward the attainment of a mature attitude toward living and achieving.

Part II consists of ten case studies of individual girls. The behavior and scholastic records of each girl, as seen and interpreted by her instructors, is described in detail. Nevertheless, in spite of the wealth of material presented in the 220 pages devoted to this part of the report, I am inclined to think that many readers will share the feeling of bewilderment and perplexity with which I am left after reading it. The material presented is frankly subjective. It consists essentially of a collation of statements about these students, made by faculty members from time to time throughout their college careers, together with anecdotal accounts of individual incidents, which may or may not have been representative of the usual behavior of the persons described. At the end of each report is a summarized statement of the scores earned by the subject on a number of standard tests, but in no instance is there any attempt to integrate this material with the rest of the case study, nor does it seem to have been utilized in the guidance of the students.

Many pages are devoted to verbatim reports of what various faculty members said about each of these girls, but in spite of this elaborate stage setting, the girls themselves make only occasional brief entrances upon the scene. We are told what courses they took each year and something about how well they did in them, but we learn little of their lives outside the classroom and the office of the faculty adviser. Even in this limited connection, one feels that the information presented is colored by a decidedly stereotyped concept of what a college student should be like, and a tendency to regard any departure from this rather narrowly defined course of development with

some suspicion, if not with downright disapproval. To this reviewer, at least, it seemed quite possible that some of the "rigidity" that the authors so frequently deprecate in their case reports may perhaps represent nothing more than a sturdy independence which refused to be molded into any preconceived pattern.

A brief characterization of the girl forms the heading of each case report. Examples of these characterizations are: "Ambition, Narrow Talent, and a Rigid Personality—Hortense"; "Insight Without Persistent Goals—Priscilla"; "Success Without Growth—Medelaine, Julia, and Judith." Again, one wishes that in some part of the twenty-odd pages of these reports, space might have been found for an account of that part of the girl's life and interests not directly concerned with classroom activities.

In this connection, an amusing account of a "picketing" episode, in which two girls marched up and down before the office of their faculty adviser, chanting, "——— is unfair to his donnees [*sic*]. He has no interest in their love-life," is perhaps suggestive. Might not a bit more attention to the "love-life" of these young students, as well as to their friendships and recreations, their home backgrounds, their hopes for the future, be more enlightening than the long pages devoted to such comments as the following from the art teacher of Hortense, the girl with "narrow talent and a rigid personality"? I quote from p. 202.

> "I think the color quality of such a talented girl—the color ability, this inborn fact—is a thing you cannot learn and cannot teach. There is a quality of tonality in her colors which has nothing to do with right or wrong. This is, in her case, violently there. She herself tries to modify it and restrain it, to calm it down. Whenever one asks me if she has taste, well, if it is a sense of moderation that is meant, in connection with her powerful natural talent—then, she has taste. (She comes from a background of no taste whatever.)"
>
> "This moderation is her ability and it makes people think that she is rather cold. I think she is very sensitive. Her taste moderates things right away."

The instructor proceeds in similar vein for several additional paragraphs. Yet he concludes (p. 203) with the statement that there seemed to him to be a fundamental emptiness in the relation of the girl's work to herself. It was herself, perhaps, but there was no core there; it was a hollow.

> "She will never (because she *can* never) go to pieces as many artists must do, once, twice, just for a moment in their lives—that is it; she will never die—no, not even for one moment."

As an illustration of the instructor's philosophy of art, all this may be enlightening, but its scientific value may well be questioned. And

this quotation is by no means unrepresentative of the 220 pages of case-study material presented. Rarely is one allowed to look at the girls directly; instead, they must be viewed through the refractive—I had almost said myopic—lenses of the college instructor. Rarely is adequate supporting evidence given for the conclusions drawn; frequently no evidence at all beyond subjective opinion is presented.

It is not clear just what purpose the case reports are intended to serve. Certainly they cannot be regarded as personality studies in the ordinary sense of the word, for it has become a truism in psychological circles that behavior under one limited set of circumstances—such as the college classroom—is an unreliable index to the behavior of the same person under other circumstances. As examples of methodology, they impress one not only as inadequate from the standpoint of obtaining the most helpful kind of information about the student, but also as cumbersome and prolix—reminiscent of the student who includes all his work-sheets in the report of a laboratory experiment. Possibly I have failed to grasp the underlying principle that the authors had in mind. In the first part of the book, the fact that students differ greatly in talents and in personality, and that these differences offer a constant and varied challenge to their instructors, is stressed. Perhaps the case reports were intended merely as illustrations of this point. That they do reveal such differences, there can be no question.

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DEVELOPMENT IN ADOLESCENCE: APPROACHES TO THE STUDY OF THE INDIVIDUAL. By Harold E. Jones. New York: D. Appleton-Century, 1943. 166 p.

This is the story of "John Sanders," one of a group of about two hundred normal boys and girls who were intensively studied over a period of seven years by the staff of the Institute of Child Welfare at the University of California. Out of a vast array of measurements, tests, ratings, and observations, which might have filled many volumes with dry-as-dust statistics, we have, instead, an individual life history that is a masterpiece of superb writing, extensive documentation, and vivid portrayal of personality development. The volume should be on the "must read" list of all who work with adolescents and youth, of all who are concerned with personality development, of all who would be scientific and critical in their methods of studying personality.

John Sanders is neither a problem child, nor a psychotic, nor a typical adolescent. He is remarkable only in that he presents in one

person a large number of the problems that are common among normal adolescents. When John was first studied in the fifth grade, the determining factors in the total situation included a respectable community background of nondescript small houses compactly built on lots of uniform size; a dominating mother who smiled quickly, but not warmly; a Casper Milquetoast father, of mediocre business ability and erratic earnings; teachers, all women, kindly rather than friendly, conscientious rather than stimulating; a physical inferiority and lack of athletic skill complicated by visual defects and ill health; average intelligence and poor-to-average school work, yet, as early as the sixth grade, accompanied by clear evidence of genuine intellectual and cultural interests; and a strong drive for personal recognition and esteem constantly frustrated by his social ineptitude and obtuseness.

A reasonably well-adjusted, rather average boy at age twelve, the weight of these multiple handicaps plus delayed maturity made John at age fifteen in the ninth grade one of the most immature, effeminate, unpopular, and unhappy individuals in the group. In the tenth grade, he barely held his own. His junior and senior years of high school brought definite progress. As a college freshman, John is still shy and quiet, but unaffected, independent, with strong and well-developed intellectual interests.

The vivid description of multiple handicaps, the four-year trend toward progressively poorer adjustment followed by recovery, the great wealth of detailed test, measurement, and observational data so well integrated into the total picture, and an extraordinarily skillful job of writing, make the development of John Sanders a fascinating story indeed.

In addition to providing an outstandingly excellent case study, the volume is an outstandingly excellent illustration of a maturing method for the scientific study of personality. It combines (1) a great variety of approaches, including appraisals of community, home, and school environments, physical growth, health, mental and motor abilities, interests, social adjustment, friends, social aspirations and skills, and emotional and intellectual development; (2) massed statistics and group norms, providing points of reference relative to a considerable population at each age; (3) follow-up or longitudinal studies of the same children over a period of years, revealing trends and ups and downs of adjustment; and (4) the focusing of all of this material on the life history of a single individual.

The method has two serious difficulties. It is impossible to present all the details; hence, the danger that conscious or unconscious selection may yield a biased picture. This difficulty seems to have been adequately surmounted: the manuscript was critically reviewed by

four members of the staff, each of whom knew John and the total body of data. The second difficulty is one of exposition. There is enough technical procedural detail and original observation here to fill dozens of learned and abstruse volumes. Extensive use is made of these data. Nevertheless, the reader is rarely aware of any interruption to the smooth flow of the exposition, which is always alive and human.

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MENTAL HYGIENE IN SCHOOL PRACTICE. By Norman Fenton. Stanford University: Stanford University Press, 1943. 455 p.

This book is both a survey of, and a program for, "mental hygiene in school practice." With a thoroughness derived from years of experience, aided by voluminous reading of the literature in the field, the author describes, appraises, and suggests procedures aimed at making the principles of mental hygiene pervasive in the life of the school.

The intent of the book is to persuade as well as to inform. It abounds with illustrations as to how a program of mental hygiene has been introduced into various schools, and with further suggestions as to how this can be accomplished by others. These illustrations are so selected that they provide suggestions capable of being carried out in a wide variety of schools—schools that differ in their readiness to adopt a mental-hygiene program, in their financial ability to maintain it, and in the qualification of their personnel to carry it out.

Those who advocate mental-hygiene programs must of necessity define the wholesome personality which their program will attempt to develop. Definitions of the wholesome personality have frequently been criticized because they equate the wholesome personality with a harmoniously adjusted individual, without taking into account the kind of culture between which and the individual this harmony is to exist. Professor Fenton, however, both in the elaboration of his definition and in many other contexts throughout the volume, enunciates the point of view that a wholesome personality in one society may not be a wholesome personality in another society. "What constitutes good mental health," he declares in the opening paragraph of his book, "is especially difficult to define at a time of great change." The definition itself emphasizes social adjustment and social value to a far greater extent than is usual in such definitions:

> "A person may be said to have a harmonious and effective personality if he is able to accept himself and the conditions of his life with fairly persistent satisfaction; if he is normally acceptable to others as a companion and co-worker; and if with reasonable assurance and cheerfulness he takes his part in life with interest for himself and benefit to society."

Thus social acceptance and social value (not merely the feeling of social acceptance and the feeling of social value) are placed on an equal status with self-acceptance.

In this connection, we find Professor Fenton distinguishing not only appetites and needs in the dynamics of personality, but also value-energy, a concept that he considers especially important in viewing the personality in action. This concern with the personality in action leads the author to stress the fact that emotional conflicts and disturbances are inevitable, especially in a society that is full of change. The need for mental hygiene, therefore, becomes the more acute, "in order to facilitate the adjustment of citizens, young and old, to changes in the conditions of their lives."

While Professor Fenton recognizes that every one concerned with the education of the child needs an understanding of the principles of mental hygiene to such an extent that school practices will actually reflect these principles, nevertheless his discussion is not ordered in terms of the daily work of the school as it bears upon the personality of the child. Aside from three pages in the first chapter devoted to the relation between mental hygiene and the curriculum, there is no other direct discussion of the various phases of school life that mental hygiene is to pervade.

It is true that scattered throughout the volume are numerous brief comments on one or another of the specifics of school practice, and suggestions as to how these can be improved so as to further the mental health of school children and school personnel. Because most of these suggestions are good, it will be a pity if for the average reader they are lost in the context. However, the teacher who does read the book thoroughly is likely to gain from it a better understanding of children, and of herself in relation to the children, to their parents, to her colleagues, and to the school administration.

That Dr. Fenton approaches the problem not so much from the point of view of the teacher-practitioner as of the guidance counselor is evidenced by the fact that the chapter entitled *Introducing Mental Hygiene Into the School* deals with case studies of communities that added a guidance program involving special personnel to form some type of child-guidance bureau or department. Of the guidance techniques discussed, the case-study guidance-conference procedure is outlined in greatest detail. Professor Fenton regards the guidance conference as extremely valuable, not only in terms of the benefit to the particular child under consideration, but also as a means of in-service training of teachers in mental-hygiene principles.

There is very little discussion of tests, even though the author believes that tests may be used "as a point of beginning in the diagnosis of the individual child." The section dealing with school case-

work develops a detailed outline for the study of the individual in terms of needs. It also distinguishes several areas of disturbance in a child. The section dealing with the mental health of the teacher offers case histories of teachers whose emotional difficulties were reflected in their classroom approach.

On the basis of this book alone, one cannot pigeonhole Professor Fenton in any one school of analysis or psychology. The diagnostic techniques described and the discussion of personality development are thoroughly eclectic, drawing freely upon many sources. One outstanding characteristic is the combination of detailed analysis and classification plus a careful attempt throughout not to fragment the personality. The interrelatedness of community factors bearing upon the child is also stressed, as well as the lasting effect of early childhood experiences.

Professor Fenton is hopeful that the "school and other aspects of the culture-pattern in which the child is brought up may do much to counteract the effects of unfortunate earlier human relationships in the lives of children." The book concludes, however, with a warning to the mental hygienist that in his study and treatment of children he must not neglect the total social environment. Although at no time does the discussion concern itself with an analysis of our culture and how it reflects on personality, the very last chapter, under the heading, *Mental Hygiene and Social Progress,* echoes the implications of the first—that the mental hygienist is, by the necessity of his profession, a "social scientist."

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INTRODUCTION TO EXCEPTIONAL CHILDREN. By Harry J. Baker. New York: The Macmillan Company, 1944. 496 p.

Only 80 per cent of school children have normal vision, but of the 20 per cent with defective vision, 19.75 per cent have correctible defects. As a result, however, of lack of adequate eye examinations and parental prejudices against glasses, some children whose vision defects could be corrected fail to obtain the needed correction. While the percentage of partially blind or entirely blind children is small—0.25 per cent—there are fifty thousand children in this country who should be in sight-saving classes. Yet such special educational opportunities are provided for only one out of every seven of these children. Surprisingly, in view of the fact that children with severe impairment of hearing often may be mistaken as mentally deficient, special educational provisions for the deaf and the hard-of-hearing are nearly three times as good; even so, they are inadequate for the 14 per cent or more children who need them.

Nearly 2 per cent of all school children—a half million in round numbers—should be in classes for the mentally retarded, but less than one-fifth of them are actually so cared for in our schools. The epileptic child usually has been excluded from school and the first attempt to provide for the education of this type of exceptional child was as recent as 1935, when the White Special School was established in Detroit.

The above are samples of the many striking facts and figures to be found in Dr. Baker's book. But it is much more than just a statistical report. It includes historical sketches of the ways in which physically or mentally handicapped individuals have been treated in the past, and gives excellent clinical descriptions of a variety of physical and mental conditions. The latter should be exceedingly helpful to teachers, enabling them to recognize more quickly when a pupil should be referred for medical, psychological, or psychiatric diagnosis.

For example, the chapter on the psychotic child describes the schizoid or schizophrenic personality as characterized by bizarre behavior, daydreaming and seclusiveness, irritability when any one interrupts daydreams or interferes with seclusive withdrawal from the group, and so forth. Since this type of child is so often considered mentally deficient or a behavior problem, it is important that a text on exceptional children present a clear statement of the distinguishing traits of the schizophrenic personality. Few books on exceptional children, however, report as extensively and accurately on this and other neurological and psychiatric conditions as Dr. Baker has done.

Besides chapters on the specifically handicapped, there are chapters on rapid-learning, slow-learning, and mentally gifted children, several chapters on behavior maladjustments, a chapter on the educationally retarded child (with reading or arithmetic disabilities, and so on), and a chapter on remedial programs for educational disabilities. Indeed, practically all the kinds of child that teachers encounter in the classroom are discussed in Dr. Baker's text. The material is, therefore, of value to teachers of regular grades, who need to be alert in detecting the pupils who need medical or psychiatric care or different educational methods from those suited to normal children. It is also recommended to special-class teachers, since it will increase their understanding of the difficulties under which their pupils labor and offer pertinent suggestions as to teaching methods and techniques for different types of handicap. Clinical and educational psychologists, psychiatrists, and social workers who are concerned with children's problems also will find this book of considerable interest.

With so much that is good to be said about Dr. Baker's text, it is only fair to mention also the few spots at which it might benefit from some revision. The chapter on the slow-learning child might be expanded, for it does not give as definite statistics on the numbers of such pupils as are given for the rapid-learning and gifted children, nor does it have much discussion as to whether educational methods poorly adapted to the slow-learning are perhaps contributory to such behavior as truancy. The chapters on special disabilities and remedial-teaching programs also seem rather brief in comparison with many other chapters. There is a question as to why the material on enuresis is placed in the chapter that deals with such other subjects as post-encephalitic conditions and congenital syphilis, instead of being located with the neurotic-behavior section later in the book.

Incidentally, the discussion of neurotic behavior is limited to short descriptions of anxiety neuroses, hysteria, neurasthenia, psychasthenia, and mixed neuroses, prefaced by the statement that children are not generally susceptible to neurotic behavior. While such well-defined neuroses as those listed by Dr. Baker may be more prevalent in adult life than in childhood, child-guidance-clinic experience suggests that a fairly large number of children develop behavior or illness symptoms because of emotional conflicts and may be more subject to neurotic tendencies than Dr. Baker has indicated.

In discussing different viewpoints and approaches to behavior problems (pp. 377–378), Dr. Baker states that proponents of one method are apt to condemn all other methods. By way of illustration, he mentions the view that merely allowing parents to talk about their problems with their children, without active guidance from the professional worker, will be sufficient to solve the problems. It is the reviewer's impression that this concept is seldom encountered at present.

As a further illustration, Dr. Baker ascribes to the Freudian viewpoint a belief that the only effective treatment is analysis, ignoring the fact that Freudians have for a long time been interested in trying to evaluate the results of analysis and to establish criteria as to the types of situation in which it would be the method of choice. In these days, probably no one except a patient in the midst of an analysis or an uninformed lay person would regard psychoanalysis as any universal panacea.

Dr. Baker expresses the opinion that all the different points of view and methods have made at least some contribution, and that we now should attempt to draw upon all of these contributions for a more versatile and comprehensive approach to behavior maladjustments. But in succeeding chapters, he allots less space to other

viewpoints and more to his own methods than might have been anticipated after his plea for a more composite approach. However, the description of his special point of view naturally adds to the interest of his book for other clinicians. His occasional lapses from objectivity are, after all, only human and do not invalidate the recommendations of his book previously made.

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THE ATTRACTIVE CHILD. By Constance J. Foster. New York: The New Home Library, 1943. 338 p.

In *The Attractive Child,* Constance J. Foster has produced a book that every thoughtful mother should appreciate. The title may be a little misleading. One might think from it that the book would deal with the problems attendant upon rearing an unusually attractive youngster, but this is not the case. The author considers that an attractive child is no problem, but that it is the duty and privilege of every mother to make her child attractive—and that this is possible. Her thesis is that in this competitive world, every child has the need and the right to be attractive.

In gathering her material, Mrs. Foster has sought the counsel of scientific authorities on eugenics, prenatal care, and the complete postnatal care and training of a child from birth to maturity. She has correlated authoritative opinions on eyes, ears, skin, feet, teeth, allergies, children's diseases, posture, body mechanics, glands, speech, nerves, chemistry, surgery, psychology, clothes, and cosmetics.

She writes with brief, direct simplicity, and a gay, good-humored understanding of child and parent attitudes. It is easy and interesting reading.

The very young mother, with her first baby, might be wise to profit by the storehouse of helpful information and advice Mrs. Foster presents. On the other hand, she might also be somewhat overwhelmed by the unusually detailed care suggested. At the time when the ordinary routine of feeding, bathing, and growing accustomed to a baby is consuming every moment, and the new infant seems completely beautiful already, it might be only the rare young mother who could envision taking specific steps with the month-old miracle to insure attractiveness at adolescence.

Mrs. Foster's book will probably have the widest appeal for mothers of children of six years or older, when some of the problems of health, looks, and manners have become realities. Such mothers would welcome these common-sense, scientifically supported suggestions for dealing with current situations and building for the future.

The book is logically arranged and clearly indexed. It is a valuable reference work to have available in any family, bringing an unusually rich collection of information and practical suggestions together into one popular-sized, easily read volume.

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THE HISTORICAL DEVELOPMENT OF RECOVERY'S SELF-HELP PROJECT. By Abraham Low, M.D. Vol. I, RECOVERY'S SELF-HELP TECHNIQUES, HISTORY AND DESCRIPTION; Vol. II, GROUP PSYCHOTHERAPY: A RECORD OF CLASS INTERVIEWS GIVEN TO PATIENTS SUFFERING FROM MENTAL AND NERVOUS AILMENTS; Vol. III, LECTURES TO RELATIVES OF FORMER PATIENTS. Chicago: Recovery, Inc., 1943. Vol. 1, 136 p.; Vol. 2, 88 p.; Vol. III, 125 p.

In these three booklets Dr. Low, who is associated with the Psychiatric Institute of the University of Illinois, discusses his work with patients and their families and the organization known as Recovery, Inc., which he established and of which he is president. In the course of his work at the institute, Dr. Low came to feel that the patients required an understanding of and an insight into their problems that could be gained through group psychotherapy lectures. He developed his project further to include the relatives of patients, who would have to play a rôle in the patient's subsequent adjustment.

In the course of these lectures, the group gained an increased awareness not only of their individual problems, but of their common problems. They organized to overcome the stigma attached to mental illness and succeeded in obtaining some changes in legislation relating to the commitment of patients in Illinois. They adopted a motto, "Nobody must be held responsible for the kind of disease he has contracted."

In the first volume of the series under review, Dr. Low describes the obstacles as well as the help encountered in the course of the organization's development. He speaks of the enthusiasm with which ex-patients and their relatives threw themselves into the work, of the coöperation and encouragement received from the Illinois State Department of Mental Hygiene, and of how this movement spread to the other state hospitals in Illinois. This is interesting and helpful material for physicians and medical directors of mental hospitals who believe that such organizations can play a useful rôle and who want to organize groups of discharged patients.

The purpose of such groups should be, as Dr. Low indicates, to

initiate a popular mental-health movement to awaken the interest of the public in the prevention of mental illness and in the conservation of mental health. Former patients and their families, who have an intimate, first-hand awareness of these problems, can convey information in everyday, convincing terms and can stimulate interest in those circles of the public which cannot be reached through the more objective, academic approach. Essentially, it was this first-hand experience, deep conviction, and enduring enthusiasm that enabled Clifford Beers to initiate and develop the mental-hygiene movement in the United States.

In the volume on group psychotherapy, Dr. Low discusses the techniques of his treatment approach. He describes what he calls "a single interview" and "a multiple interview," and illustrates both approaches with verbatim records of what takes place in the lectures. In the single interview, the discussion is between Dr. Low and the patient; the other patients are present, but do not participate. In the multiple interview, the other patients are asked to participate. The topics that he discusses with the patients vary. Among them are "The Vicious Cycle of a Panic," "The Fear of Being Misunderstood," or "Dual Standards of a Self-Conscious Person," and so on. The reader is left with the impression that the question-and-answer method is an important part of Dr. Low's technique. Apparently, these interviews are planned to interpret abnormal psychological and physiological reactions on a superficial level. There is no evidence of an attempt to go into the deeper dynamics of a Freudian interpretation or other psychopathology, but since Dr. Low gets results, we are not going to question his technique. According to him, his approach is more of a "discipline."

Psychotherapeutic results can be obtained by various forms of approach—*i.e.*, the Coué method, hypnosis, suggestion, and the various schools of psychoanalysis. The late Dr. Paul Schilder used the psychoanalytic approach in his group-psychotherapy sessions and claimed definitely favorable results. The reviewer uses a similar approach in group psychotherapy. The participants in the group discuss each patient's abnormal reactions and try to interpret the unconscious motivations of his behavior. The results are favorable.

One thing is certain—people who are mentally ill require some understanding and guidance, and the restoration of self-confidence, even after their acute symptoms have been relieved by shock treatment. It is unfortunate that individual psychotherapy cannot be made available to all who require this type of treatment. But group psychotherapy, when practiced with skill, provides a short cut. The armed forces have come to this conclusion, and one notes with

gratification that both the army and the navy are utilizing group therapy, not only as a morale builder, but also as a therapeutic approach.

In his third volume, *Lectures to Relatives of Former Patients,* Dr. Low has made a contribution toward the recovered patient's adjustment in his home setting. It is his contention that since the patient is not completely well upon his discharge, it is important to give his family an understanding of his problems and behavior. Dr. Low regards this measure as part of a preventive program.

The subjects discussed with relatives cover environmental irritations and individual response, home adjustment after hospitalization, the tempermental deadlock, and so on. In a course of fifteen lectures, Dr. Low explains to members of the family the dynamics of behavior—including what produces so-called abnormal behavior, and stresses the need for understanding and self-expression as a means of averting total collapse.

These pamphlets are timely and provocative, especially during this period of neuropsychiatric casualties and shortage of trained psychiatrists. They are worth reading even if one is not in agreement with Dr. Low's technique. Group psychotherapy has become an essential short cut in meeting the needs of people who require treatment. The real problem before us now is to evolve techniques that are more precise and that provide the patient with an understanding of himself that will carry over to the personal problems he encounters in the future.

LOUIS WENDER.

Neurological Institute, New York City.

RACE AND RUMORS OF RACE. By Howard W. Odum. Chapel Hill: University of North Carolina Press, 1943. 245 p.

Any help that can be given to the American people in viewing the problem of a bi-racial culture in a reasoning rather than in the prevailing irrational way should be greeted with enthusiasm. At present the subject seems to be dealt with wholly through the emotions, except for a small body of liberal educators and public servants, both in the North and in the South, both white and black, who are studying the situation constantly and trying to work out the answer to "the American dilemma."

Dr. Odum, professor of sociology and Director of Research in the Social Sciences at Chapel Hill—that source of light on American problems—has made a study of rumors regarding race during the year 1942–1943. He was assisted by a group of trained investigators, and every rumor that could be found after a most painstaking search was scrutinized and its source and any validity in

its subject matter determined. Here we have objectivity of approach to a vexed question at its best.

The study is not easy reading in spite of the fascinating content. Sometimes it is difficult to separate story from unfounded rumor, the author's treatment is so informal. But this casual approach adds to the human quality of the book. These are prevailing stories—stories that are forming the opinions and attitudes of people living at the present time—and the picture is not reassuring.

It should be stated emphatically that the author's preface is an essential aid to an understanding of the purpose and method of the book. Many people skip prefaces; this one is too important and too interesting to treat thus lightly. In it Whitman is seen to be a factor in determining the trend of the author's thinking: "By God, I will accept nothing which all cannot have their counterpart of on the same terms." Can any real American accept less? He closes this preface with a challenge to all who value and search for healthy-mindedness: "The eager quest for a new covenant through scientific and coöperative endeavor on new high levels leaves no place for bitterness and hate, for name-calling and blame, for flight from that reality which is America's heritage and opportunity."

The book is divided into four parts. The second part contains the rumors and stories discovered in this carefully planned search. Some of the rumors are so fantastic that one marvels at the human being's capacity for believing. Others are widely prevalent and soberly held by intelligent people. There has been great objection on the part of Southern people especially to the airing of these stories, and the tensions arising from them. Some believed "that if an attempt was made forcibly to abolish segregation throughout the South, violence and bloodshed would result." But the question at once followed, "Now since we have this problem, what can we do about it?" The last chapter of this second section presents clearly the fact that the problem is for the nation as a whole to solve; the South can no longer claim it and insist that the solution be determined by that section of the country alone.

The first section gives the framework in which these rumors are set and cites the changes that are taking place more rapidly than the masses of Southern people—or of Northern people, for that matter—realize. The third section points to "the way on." Only now, forced by the exigencies of this war, are we beginning to understand the global nature of the color problem—to realize that, far from being a sectional matter, it is a problem not only of the United States, but of the world, for, viewed globally, the white

race is the minority group. If we in this country are helpless before the need to find solutions, the world outlook is not reassuring.

The ability of the Negro himself to take a position of leadership in suggesting solutions is indicated by a careful reading of the statement of the Durham Conference, a gathering of leading Southern Negroes, which is quoted in full in Chapter XXI. The Durham Conference dealt with questions of political and civil rights; industry and labor; service occupations; education ("it is imperative that every measure possible be taken to insure an equality of education to Negroes, and, indeed, to all underprivileged peoples"); agriculture; military service; and social welfare and health.

It is interesting that in no connection does this carefully prepared statement urge the "social equality" of Negroes, although it is in that field that the larger number of rumors are found and it is there that fears have their most compelling influence. Indeed, the statement goes so far as to say in its introductory section: "We regard it as unfortunate that the simple efforts to correct obvious social and economic injustices continue, with such considerable popular support, to be interpreted as the predatory ambition of irresponsible Negroes to invade the privacy of family life." The best answer to the frequent question, "Would you like your sister (or daughter) to marry a Negro?" is that such a query is totally irrelevant. It is only another instance of the lengths to which fear will cause the otherwise intelligent person to go.

In the last section the author becomes highly Socratic; question follows question until the reader is forced to realize the exceeding complexity of "the American dilemma." The Negro "must have his pro-rata position in the social order." Can the South accept and coöperate in an effort to bring that about? But the rest of the nation must not become complacent in this matter. Their "credo" is more confused, less consistent, than that of the South. It abounds in fine phrases, but is too often motivated by timidity. There must be a new credo for the entire nation and the grievances of South against North must be recognized as long-standing causes of many of the fears, particularly in the economic field, that underlie the attitudes of Southerners regarding Negroes. Frankness, complete honesty, are called for, first, to help in changing attitudes by dealing realistically with attitude-forming rumors, then to aid the effort to apply literally the truths that we profess to hold as self-evident. Thus shall we not only do justice to a long-suffering minority, but gain in health of mind and spirit as a nation.

ELEANOR HOPE JOHNSON.

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PRINCIPLES AND PRACTICE OF REHABILITATION. By John Eiselle Davis. New York: A. S. Barnes and Company, 1943. 208 p.

This book presents a statement of certain procedures of psychiatric therapy relating primarily to hospital practice. It throws little light on the problem of active psychiatric work with individuals who need to be rehabilitated back into their communities. As a statement of working principles in the broad field of occupational therapy, it has some value.

The material of the book is replete with quotations from other authors, many of whom would no longer be considered as representing a modern point of view Between quotations there is an attempt to link up sections under the general theme of "rehabilitation." This gives to the book a curious fragmentary quality. The concepts of modern psychotherapists are merely hinted at. The book has rather the quality of a set of lectures aimed at the non-medical personnel of state and veterans hospitals. It deals largely with one aspect of treatment, mainly on the occupational-therapy level, and to that extent its title is misleading.

To the vast group of psychiatrists, psychologists, and social workers who are intimately involved in contemporary rehabilitation efforts, this book will be disappointing.

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THE NATURE AND TREATMENT OF MENTAL DISORDERS. By Thomas Verner Moore, M.D. New York: Grune and Stratton, 1943. 312 p.

This volume is the product of the mind of one who has had a long, rich experience as both priest and psychiatrist. It is "an attempt to make a contribution to our understanding of mental disorders and to illustrate a wide variety of techniques in dealing with the many and varied problems with which the psychiatrist is confronted." It begins with the concept of mental disorder, including types of reaction, and in the second chapter continues with brief reviews of the different ideas of Freud, Jung, Adler, and Alexander.

Dr. Moore believes that the time is overripe for the psychoanalysts to submit their theories to empirical study and statistical procedures. Although there is much to be said in favor of this, and the rôle of statistics is well established throughout the field of basic scientific work, the actual value of biometrical procedures in the realm of certain mental functions and emotional twists is a debatable matter.

Unless one can know a great deal about what composes the statistics and what it is really important to include, these not only confuse the issue, but actually kill the vital core and essence of the subject.

To the psychoanalyst, the facts of experience are organized and constitute a world of reality. Statistics in terms of the individual patient can be constructed by him, but there are too many variables in the numerous personality constructions to fulfill the laws of the statistical method when it is applied to groups.

Certain correlates and intercorrelates are possible, but they seldom deal with other than the more superficial presenting phenomena of the personality or the disorder. Perhaps the time will come when all the rules of the scientific method may be applied effectively, but until then much will remain in the realm of experience and philosophy.

Philosophical components and concepts will probably always remain with us. As Havelock Ellis stated: "A philosophy is the house of the mind and no two philosophies can be alike because no two minds are alike." This is doubtless one of the principal reasons why interpretations of mental behavior fall so far short of universal satisfaction.

The book is very readable, containing a wealth of pertinent case notes. The sections on the emotional difficulties that arise in the midst of family problems, on those arising from the complexities of married life, on phobias, and on hysterical manifestations are particularly informative. The chapters on family reorganization, educational therapy, and bibliotherapy contain many useful suggestions.

A somewhat different arrangement of the subject matter and a number of additions would be necessary to qualify it as a textbook for students. However, it should become popular as supplementary reading for university courses, and specialists in clinical psychiatry will find much to think about if they peruse it carefully.

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NOTES AND COMMENTS

Compiled by

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REPORT OF THE HERSHEY CONFERENCE ON PSYCHIATRIC REHABILITATION

The National Committee for Mental Hygiene has made public the recommendations of a representative group of psychiatrists, internists, and medical educators as to ways of providing the professional care needed by more than 2,000,000 men who, according to estimates made by this group, have been rejected by Selective Service or discharged from the army and navy for psychiatric disabilities.

These recommendations were formulated by a committee composed of David P. Barr, M.D., Professor of Medicine, Cornell University Medical College; Walter L. Palmer, M.D., Professor of Medicine, University of Chicago School of Medicine; Thomas A. C. Rennie, M.D., Associate Professor of Psychiatry, Cornell University Medical College; George S. Stevenson, M.D., Medical Director, The National Committee for Mental Hygiene; and George W. Thorn, M.D., Hersey Professor of the Theory and Practice of Physic, Harvard Medical School.

This committee spoke for thirty physicians and community workers who met in conference at Hershey, Pennsylvania, on February 1, 2, and 3 of this year, as guests of the Commonwealth Fund of New York City. Medical officers of the army, the navy, the army air forces, the United States Public Health Service, and the Veterans Administration were present by authority, and participated in the discussion at this conference, but were unable, because of their official position, to join in its recommendations.

Realizing that a large proportion of those men who might benefit by professional care would not seek it, the conference estimated that if no more than 50,000 to 150,000 men did turn to psychiatrists for help, it would be impossible to care for them with the resources now at hand. Discussion centered, therefore, on ways of increasing psychiatric service and of training physicians in general practice to be more helpful to men with difficulties arising from emotional as well as physical causes. The conference expressed its belief that the demand for such care would increase rather than diminish, and would

be particularly pressing if unemployment should become widespread.

The conference committee gave first place among its recommendations to a plea for more psychiatric training of medical officers in the army and navy, where such training in short courses, it was reported, has already proved highly successful.

"It is urgently desirable," the committee reported, "that the psychiatric training of picked medical personnel in military installations be continued and expanded. The circular recently issued by the Surgeon General of the Army calling the attention of men about to enter the Medical Corps to the opportunities for such training is a welcome step in this direction."

The committee also stressed the need of "an impartial restudy of the therapeutic facilities and policies of the Veterans Administration with respect to veterans with psychoneurotic reactions, and of legislation regarding compensation for such veterans, which has a direct bearing on therapy." In this connection, according to the conference report, it was found after the last war that in many instances the compensation provided by law for service-connected disabilities was an obstacle to treatment and recovery among psychoneurotic veterans. The conference found, too, that the veteran with handicapping emotional difficulties is not usually in need of hospitalization and can be treated more successfully in the doctor's office or the out-patient clinic. The committee urged veterans' organizations, medical associations, the national Executive, and the appropriate committees of Congress to lend support to a study of these problems as they affect the Veterans Administration.

Other recommendations for emergency action were as follows:

> "Facilities *other than hospital care* (such as the mental-hygiene units) for the treatment of men with psychoneurotic reactions might well be further developed in military installations in the hope that many more men can be retained in service for treatment which is not at present available in civilian life.
>
> "The National Committee for Mental Hygiene should intensify its efforts to arouse and inform the public, and in particular the church, the schools, industrial management and labor, as to the needs and care of veterans with psychoneurotic reactions; and to promote the training and efficient use of psychiatric social workers and other auxiliary personnel in community services for such veterans.
>
> "Physicians engaged in the practice of general medicine need education on the neuroses and their care. An experimental course, or courses, at the postgraduate level should be set up promptly to develop content and methods for such education. In the light of such experiments a nation-wide program should be undertaken. Teaching personnel should be carefully chosen in view of the fact that not all psychiatrists are prepared to undertake this responsibility. Special effort should be directed also to physicians in industrial and college medical services."

Turning its attention to the long-range problem of giving more physicians an understanding of emotional disorders and their treatment, the committee also made the following recommendations:

> "For the graduate training of internists and general medical men already introduced to, or interested in, psychiatric aspects of medicine as a result of their war experience, fellowships should be made available, and these stipends should be large enough to attract men already well equipped professionally and with family responsibilities.
>
> "Patterns for comprehensive medical care and the teaching of comprehensive medicine to undergraduates and house officers are urgently needed. To this end psychiatrists and internists should jointly carry major teaching responsibility in medical out-patient clinics and wards. In the present emergency medical schools should be encouraged to give priority to such duties in the assignment of suitably trained persons and to experiment freely with clinical and teaching methods.
>
> "Graduate training for comprehensive medical care would be facilitated if the American Boards of Internal Medicine and Pediatrics credited to a limited extent appropriate experience in psychiatry and if the American Board of Psychiatry and Neurology reciprocally credited appropriate experience in internal medicine or pediatrics. These are the boards which examine and accredit specialists.
>
> "Training for the specialty of psychiatry should give increasing attention to the treatment of the psychoneuroses as they present themselves in both psychiatric and general medical practice, to the care of ambulant patients, to the use of auxiliary personnel (psychiatric social workers and clinical psychologists), and to community services for the promotion of mental health."

National Committee for Mental Hygiene Undertakes Kindergarten Project

The National Committee for Mental Hygiene has undertaken a project to work out at the kindergarten level techniques that will promote the wholesome adjustment of young children to the school program. Mrs. Evelyn D. Adlerblum, psychological counselor, who received her master's degree at Teachers College, Columbia University, and who has done considerable work with young children, has carried on the project at Public School 33, 418 West 28th Street, Manhattan, during the past school year. Sponsored jointly by the board of education and the Public Education Association, the project is part of the All-Day Neighborhood School Demonstration, which aims to help in the personality development of all children in an informalized all-day program.

As Mrs. Adlerblum explains, kindergarten teachers would like to observe their children more intimately than the regular classroom procedure permits. For the child this initial step in his school experience should be successful and fulfilling, in order to give him a favorable attitude toward the rest of his long school career. All

children have different starts, different homes. One child may adjust quickly, another may take a while to find himself in this larger world of new faces, varied personalities, and new disciplines. The teacher wants to help them all.

The supplementary kindergarten group, led by Mrs. Adlerblum, meets during regular school time for an hour on Monday, Wednesday, and Friday morning. Usually five children are taken out of the kindergarten class to a separate room equipped with toys, books, blocks, and plastic materials for this project.

The small group permits more free play and an opportunity for the children to select the toys that they want, as well as to play whatever they like. Leisurely discussion and dramatic play help to enrich information that the children have already gained in kindergarten.

At P. S. 33, the two regular kindergarten teachers take turns at "sitting in" in order to observe individual differences in their pupils, such as attention span, adaptability to one another in play situations, choice and handling of toys and materials, hidden fears and hostilities.

Lack of time makes it impossible for every child from the kindergarten to go into this special class, although every child ought to have a chance. Teachers and psychiatric counselor select those children who seem most in need of intimate group work. At present, the children chosen for this experience are those who show need of the warmth and understanding of a smaller group as a stepping-stone to a larger group. They may be selected from one of three categories: children who have spent several terms in kindergarten, but who are not old enough to enter the first grade; youngsters who are shy and withdrawn in behavior, and those who come from homes where little English is spoken; and children from broken or disturbed homes.

Sometimes as many as sixteen nationalities are represented in the kindergarten at Public School 33. Some of these children speak very little English when they first enter the kindergarten. This language handicap is in itself a factor in keeping them from expressing themselves adequately or being able to talk to others and feel at home in the group.

In the small group, stimulated by the counselor, children can develop a vocabulary and develop a facility with language that will prepare them for good work in the upper grades.

The psychological counselor's program is planned to bring out the child's needs and to help his emotional growth. Discussion is perhaps started by looking at a picture book, which encourages the children to talk about themselves and their experiences, or through free play with toys and play materials while the counselor observes the youngsters' relations to one another and how they dramatize

their emotional needs. At the end of the period, when they quiet down while a story is being read, the children can speak up and identify themselves with characters in it.

The program has definite values. On the basis of what the child reveals as his needs, plus information that teachers have about his home and the use of simple maturity tests, teachers can get a more complete understanding of each child. Having this background, they can help the child to adjust faster and to get the most out of his school experience.

Mental-Hygiene Clinics for Veterans and Community Service Established in Westchester County, New York

On August 6, 1945, the Board of Supervisors of Westchester County appropriated funds for the establishment of a county-wide network of mental-hygiene clinics, to serve veterans, their families, and the community—both adults and children. These clinics will constitute a division of mental hygiene in the county department of health, with a staff appointed by the commissioner of health.

The plan for these clinics originated with a committee of the Westchester County Council of Social Agencies, which later became the Mental Hygiene Association of Westchester County. It is planned to establish six clinics in various parts of the county. The locations chosen will depend upon community needs and the accessibility to surrounding areas. The plan of organization of the clinics provides for a central staff, consisting of two psychiatrists, a case-work supervisor, six psychiatric social workers, a psychologist, and a clerical staff. The psychiatrist at each clinic will be assisted by a competent psychiatric case-worker who, in addition to her own duties, will carry on also a certain amount of therapy in selected cases—under the direct supervision of the attending psychiatrist. The psychotherapy in the more complex cases will, of course, be personally performed by the psychiatrist.

The plan was very minutely worked out by the Westchester County Mental Hygiene Association and presented to the Westchester County Medical Society. This body, after careful study, endorsed it. The plan was also carefully studied by the commissioner of health of the county, the commissioner of public welfare, veterans groups, nursery-school councils, parent-teacher associations, and so on, and was enthusiastically endorsed.

With the backing of these groups, the commissioner of health, Dr. William A. Holla, presented it to the county board of health, and in April, 1945, Dr. Edwin G. Ramsdell, chairman of the board of health, and Dr. Holla presented it to the county board of supervisors, which,

after due deliberation, ratified it and appropriated funds for carrying it out.

So far as is known, the proposed plan involves more complete county coverage in terms of accessibility of service than is offered by any existing mental-hygiene clinics under public auspices. No other tax-supported plan to date has used the device of resident social workers coupled with itinerant psychiatrists, case supervisor, and psychologist—an arrangement dictated by the shortage of psychiatric personnel.

Special arrangements are being worked out to allay any suspicion or feeling of stigma that a veteran may attach to attending a mental-hygiene clinic. The clinic will be placed in a community setting in which not only the veteran and members of his family, but also other members of the community may attend it.

The newly formed Mental Hygiene Association of Westchester, which originated and promulgated this plan, is to act as the educational and interpretative arm of the clinics. The association plans, with the coöperation of the health department and other agencies, to hold study sessions, discussion groups, and conferences with the public and professional groups who are so situated as to be in touch with psychiatric problems, particularly general practitioners, pediatricians, ministers, school principals, teachers, nurses, social workers, and so on.

The education committee, which is a branch of the mental-hygiene association, has already started along these lines and has had several particularly successful meetings. In May, an all-day child-guidance institute was held at Sarah Lawrence College. A capacity audience of some 170 parents and teachers heard talks by Dr. Lawson Lowrey and Dr. Lois Murphy. There was an active discussion in which Dr. Alice Keliher and Dr. Edward Liss participated.

A second mental-hygiene conference was held for the clergy at Sarah Lawrence College on June 12. The subject was "The Clergyman's Rôle in Mental Hygiene." Speakers included Dr. Aloysius Church, of Lincoln Hall; Lt. Col. Ralph T. Collins, an army psychiatrist; Dr. Luther E. Woodward, of The National Committee for Mental Hygiene; and Dr. Seward Hiltner, of the Federal Council of Churches of Christ in America.

Members of the Westchester County Mental Hygiene Association have already addressed a wide variety of groups, and many more meetings are in the offing. In the fall, recordings of radio programs dealing with returning servicemen are to be available for meetings. For large gatherings, the American Theater Wing has consented to put on dramatizations.

The Westchester mental-hygiene-clinic plan is unique in the flexibility of the relationship that will exist between the county health department and those cities in the county which are not in the county health area, but have their own health departments under the state department of health. By special arrangement with the state authorities, the county will be reimbursed for half the cost of the mental-hygiene services, and then may provide service to any city not within the county health area that desires such service at cost. Mount Vernon, one of the cities outside of the county health area, has already signified its desire to contract for mental-hygiene service under this plan. The city of Yonkers is also considering the plan and at this writing is expected to endorse it and to appropriate funds to be able to participate.

This plan will be watched with particular interest by physicians throughout the state, since the Mental Hygiene Association of Westchester County, which is the dynamic force behind the plan, is essentially a lay organization similar in function to the well-known tuberculosis associations in their field. It will be noted, however, that the association has on its board of directors very adequate medical representation. Dr. Lawrence D. Redway, chairman of the medical society, and Dr. Lawson G. Lowrey, Director of the Brooklyn Child Guidance Clinic and resident of the county, are vice-presidents of the organization. The board, which numbers about fifty, includes sixteen physicians, six of whom are psychiatrists, the rest being specialists in other fields and general practitioners.

Mental-Hygiene Activities in Ohio

Ohio's Ninety-sixth General Assembly accomplished far less for the state's new mental-hygiene program than public opinion demanded, although compared with the inaction of preceding legislative sessions its record appears quite substantial. It voted some $17,000,000 for "additions and betterments" at mental-hygiene institutions, which will permit the construction of slightly more than 8,000 *new beds* for the mentally ill, the mentally defective, and the epileptic. Former Governor Bricker's mental-health committee had recommended $37,000,000 for the construction of 18,000 additional beds as immediately necessary. Money was also provided for the construction or purchase of receiving hospitals at half a dozen points, but no specific appropriations were made for the operating expenses of these new units.

An impressive showing of strength by representatives of many citizens' and professional mental-health organizations in legislative committee hearings was instrumental in obtaining an increase of $277,000 for mental-hygiene institutional personnel above the amount

in the house-approved appropriations. Although this increase fell considerably short of the $500,000 requested, it is almost $200,000 above the amount recommended by Governor Lausche in his executive budget. Even with this added amount, however, the total appropriation available for personnel in the division of mental hygiene will fall far short of meeting the critical personnel needs during the biennium. No provision was made for salary improvements, employment of higher-salaried personnel, or reduction of the twelve-hour day. It is probable that the ratio of ward employees to patients can be gradually reduced to 1 to 13.5, but no improvement beyond this is to be expected with the limited funds appropriated by the legislature.

The legislature provided no funds for resident and mobile clinics, although only the small sum of $50,000 had been requested for this purpose. Only $25,000 for research and $9,250 for mental-hygiene education and training films were appropriated as over against the request of $75,000 and $25,000, respectively, for these two important programs. The family-care program received an appropriation of $25,000.

A series of ten bills originally introduced to carry out the principal legislative recommendations of the mental-health committee appointed by former Governor Bricker was finally consolidated into four major measures. The legislation finally adopted provides a minimum program to modernize Ohio's mental-hygiene laws. The major changes are an improved administrative code in the mental-hygiene field and the establishment of adequate legal machinery for the examination, commitment, and treatment of mentally deficient and psychopathic offenders convicted of a felony. Of the twenty-one legislative recommendations of the Bricker Committee, all but five were enacted into law.

Much interest in the organization of a state mental-hygiene society has developed in recent months among various groups throughout the state. This interest has been stimulated by the reorganization of the Division of Mental Hygiene in the State Welfare Department; the new and vigorous leadership that its commissioner, Dr. Frank F. Tallman, has given in the year he has been in Ohio; the recent session of the legislature; and other developments. A district mental-hygiene organization covering several counties and centered in Akron has recently been formed. Similar district societies are expected to develop elsewhere in the near future and will pave the way for the eventual formation of a state mental-hygiene society.

In Cleveland efforts are being concentrated on the establishment of critically needed clinical services. A veterans' mental-hygiene unit, located at the Veteran's Information Center, to provide evening clinic

services, was expected to be inaugurated late in September. Volunteer services will be furnished by staff psychiatrists of the Cleveland State Hospital and members of the local chapter of the American Association of Psychiatric Social Workers. Meanwhile, plans are being formulated under the auspices of the Cleveland Mental Hygiene Association to establish a community clinic on a three-year-demonstration basis to serve adult psychoneurotics.

It will be recalled that after World War I, the police forces in our larger cities were important factors in community tensions, conflicts, and general unrest. Among the causes of these disturbances, two may be mentioned: (1) faulty training and (2) inadequate methods of selecting police personnel.

Many World War I veterans were recruited for positions in city police forces, and because of the wholly inadequate method of examination for applicants, some veterans with unsuitable personality patterns became members of these forces. Such men were quick to swing their clubs and go off on a tangent without sufficient cause. It is hoped that the progress made in psychiatric screening during this war may be carried over into civilian activities. The Cleveland Mental Hygiene Association, therefore, has proposed to the proper officials of the Cleveland city government that steps be taken as soon as possible to insure adequate psychiatric examination of all applicants for positions in the city's police force. A receptive attitude has been shown toward this proposal, and there is every reason to suppose that it will be acted on. This measure is one that might well be suggested by other mental-hygiene associations to their city and state officials.

Connecticut Institutes a Mental-Health Program

A program for meeting more adequately the mental-health needs of the state has recently been instituted in Connecticut with the passage of a bill entitled "An Act Establishing a State Plan for Mental Health." The bill contains the following four provisions:

1. Each state hospital for mental illness shall establish psychiatric clinics for adult persons, including those who are or have been under the legal control of mental hospitals.
2. Any general hospital in the state may apply to the state department of health for funds to be used in the establishment of a psychiatric service. Said department shall grant funds to any such hospitals provided the plans for such psychiatric service shall be approved by the said department.
3. The Mansfield State Training School and Hospital and the Southbury Training School shall establish clinics for retarded persons and persons suffering from epilepsy.
4. The state department of health shall expand its program of psychiatric clinics for children.

The funds for these various items were included in the budgets of the respective state hospitals and schools for mental defectives and in the state department of health, and were made available in the appropriations to the respective agencies.

Maternal and Child Welfare Act of 1945

The proposed "Maternal and Child Welfare Act of 1945" is an independent act of legislation which would enable the states to make more adequate provision for the health and welfare of mothers and children and for services to crippled children. It is based on the principle of federal grants-in-aid to the states, and places administrative responsibility on state governmental agencies.

The bill sets forth the procedures through which the federal and state agencies would coöperate and provides a method for consultation with public representatives. Three of the important services to be rendered under the bill are "preventive maternal and child health work, including mental health; the training of personnel; and guidance and social service to or in behalf of children who are dependent, neglected, or delinquent."

Child Welfare Information Service Opens Office

A new, voluntary, non-profit organization, entitled Child Welfare Information Service, Inc., has opened its office at 930 F Street, N. W., Washington 4, D. C. This service plans to give the public information on the activities of Congress and the federal agencies as these relate to the general welfare of children and youth. From time to time a bulletin will be issued.

The officers of the new organization are as follows: president, Mrs. Eugene Meyer; vice-presidents, John Dewey, Mrs. Dorothy Canfield Fisher, Homer Folks, Leonard W. Mayo, C.-E. A. Winslow, and George J. Hecht, publisher of *Parents Magazine*, who is also treasurer of the organization; secretary, Mrs. Gertrude Folks Zimand; and executive director, Bernard Locker.

National Conference of Social Work Reëstablishes Mental-Hygiene Section

The National Conference of Social Work is reëstablishing its mental-hygiene section, which was discontinued some years ago when the conference was reorganized. The section will deal with such topics as the maintenance of mental health, institutional care, clinics, and so forth. Mrs. Elizabeth H. Ross, Secretary of the Joint War Office of Psychiatric Social Work, Philadelphia, is chairman of the com-

mittee in charge of the section. The other members of the committee are as follows:

Term expiring 1946: George Gardner, of the Judge Baker Guidance Clinic, Boston; E. L. Johnstone, Superintendent of the State Colony, Woodbine, New Jersey; and Jeanette Regensburg, Associate Professor of Case-work, Tulane University School of Social Work, New Orleans.

Term expiring 1947: Ruth Lloyd, of the Neurological Institute of New York, New York City; Lila McNutt, Director of Psychiatric Social Workers, Division of Mental Hygiene, Department of Welfare, Madison, Wisconsin; and Lee Yugend, Case-work Supervisor, American Red Cross, Winter General Hospital, Topeka, Kansas.

Term expiring 1948: George K. Pratt, author of *Soldier to Civilian*, Westport, Connecticut; Mary Rall, District Supervisor, United Charities of Chicago; and Mrs. H. C. Solomon, Head of Psychiatric Social Work Department, Simmons College of Social Work, Boston.

American Association on Mental Deficiency to Hold Postponed Meeting

Dr. E. Arthur Whitney, President of the American Association on Mental Deficiency, has announced that the association is proceeding with plans to hold its annual meeting in Cleveland, Ohio, November 28 to December 1, of this year. The meeting had been postponed because of O. D. T. restrictions on conventions, which were relaxed with the ending of the war.

Colonel Menninger on "Report to the Nation" Program

"Every one of us is susceptible to an emotional upset of a severity ranging all the way from fingernail-biting to suicide." This statement was made on the *Report to the Nation* program (June 24) by Colonel William C. Menninger, Director of the Neuropsychiatry Consultants Division, Office of The Surgeon General. Colonel Menninger sought to drive home to the listening audience that psychoneurosis is a universal phenomenon. Communities, he said, must shoulder the responsibility for helping the returned psychoneurotic veteran to help himself. One way to do this is by promoting understanding of psychoneurosis—"eliminating the mystery and obscurity now surrounding the subject." Most communities, he added, have at least one physician sufficiently informed in psychiatry to explain and discuss it before various civic organizations. "This," he concluded, "could be a vital part of one of the most essential reconversion jobs in America—the readaptation of our mentally wounded soldiers to peace-time living."

Recent Appointments

The Washington State Department of Health has announced the appointment of S. Harvard Kaufman, M.D. as head of the department's mental-hygiene section. Under Dr. Kaufman's direction mental-hygiene clinics serving the larger communities in the state are being organized. It is planned that intake emphasis will be on veterans and children, but services will be available for every one, including the juvenile courts. The program of the several clinics will be primarily therapeutic and secondarily diagnostic.

Applications are being received for psychiatric social workers, psychologists, and psychiatrists who have had special training in child guidance or mental hygiene. For further information, write to S. Harvard Kaufman, M.D., Head, Mental Hygiene Section, State Department of Health, 320 Smith Tower, Seattle 4, Washington.

Dr. David A. Young, assistant professor of psychiatry and neurology at the University of Utah School of Medicine, Salt Lake City, has been appointed superintendent of mental health for the four state hospitals of North Carolina. This is a newly created position which became open September 1, 1945. The program of which Dr. Young will be in charge aims to provide better state-hospital care. It includes a plan to purchase from the United States Government the army hospital (now abandoned) at Camp Sutton. This hospital would care for about 1,000 of the senile arteriosclerotic group, thus freeing beds for the care of patients whose prognoses are more hopeful.

Dr. William C. Inman, Danvers, Massachusetts, has been appointed director of the Division of Mental Hygiene and Research of the Massachusetts State Department of Mental Health. Dr. Inman succeeds Dr. Edgar C. Yerbury, who resigned to become superintendent of the Connecticut State Hospital at Middletown. Dr. Inman graduated at Tufts College Medical School in 1924. For the past few years he has been assistant superintendent at the Danvers State Hospital.

State Society News

Illinois

The Illinois Society for Mental Hygiene reports that its Committee on Functions and Responsibilities, under the chairmanship of Mrs. George R. Dean, has recently made a careful study of the society's functions and responsibilities and that as a result of this study the following recommendations were made:

1. *Service.*—The committee recommended that the society turn over its service to individuals to another agency and that the professional time thus saved be invested in services to agencies and communities.

2. *Education.*—The committee recommended that this aspect of the society's program be stressed even more than it is at the present time, and that an educational secretary be employed to assume responsibility, under the direction of the medical director, for the development and conduct of the educational program and the educational activities of the society.

At the present time the society is emphasizing the need for developing and coördinating educational programs to help civilians understand their emotional problems caused by the war situation and the emotional problems of returning service men. The society is prepared to coöperate with any group or agency by (1) supplying them with speakers and lists of appropriate movies and literature, (2) helping them plan their program, and (3) conducting a program for them.

3. *Research.*—Research should be recognized as a necessary function of the society. Systematic investigations and surveys of community health needs and resources should be undertaken. Such studies should afford information that could be used as a basis for recommendations as to the extension of mental-hygiene services and a more effective use of existing resources. Research activities might include certain research education projects or social studies on the mental-hygiene aspects of other community-agency programs.

By means of questionnaires and personal interviews the society is continuously obtaining information regarding mental-hygiene resources in the community. This year, for the first time, the society has compiled information on the vocational-guidance services in the city, the psychiatric units in general hospitals, and the psychiatric services in case-working agencies.

4. *Promotion.*—The society must recognize a definite responsibility for promoting more adequate psychiatric facilities, both public and voluntary, both inpatient and out-patient. It is also concerned with the development of well-trained personnel to staff such facilities. Activity in this respect should be directed toward the raising of standards in our state hospitals to meet requirements for residences, fellowships, and ultimately internships.

The society must take into account the mutual interdependence of Chicago and down-state in the development of mental-hygiene activities, and the committee is of the firm opinion that the society cannot achieve its educational goals or use its resources adequately unless it is operated as a state-wide agency.

The society has coöperated with various groups and agencies in the state, such as the Mental Hygiene Division of the Illinois Department of Public Welfare, the Illinois Board of Public Welfare Commissioners, to promote more adequate psychiatric services.

In the field of legislation the society has coöperated with groups in the state in securing passage of H.B. 397 (Revised Mental Health Act), and S.B. 583 (An Act in Relation to Vocational Education). At present the society is coöperating with The National Committee for Mental Hygiene in securing passage of H.R. 2250 (the National Neuropsychiatric Institute Act).

Iowa

During the past three months the educational program of the Iowa State Society for Mental Hygiene has been carried forward chiefly by Lieutenant Colonel Robert S. Shane, Medical Director of Selective Service for Iowa, who has held seventeen district meetings over the state. He has called together Selective Service officials, welfare officials, the American Legion and Legion Auxiliary, Parent-Teachers association, the Red Cross, and other agencies. Seven counties have appointed chairmen and plans are under way for the organization of chapters for study groups and promoting projects in mental health.

The society now has a membership of about 700 and is planning for a semi-annual meeting to be held in October. A list of 30 pamphlets is available for the membership upon request and the services of a speaker's bureau are offered to service clubs and societies.

Maryland

The Mental Hygiene Society of Maryland has received additional funds of $12,800.00 to amplify its clinic work with children, adults, and certain ex-service men and women. This increase in budget creates additional jobs on the staff for a psychiatrist and two psychiatric social workers. The actual work is not yet under way because of the lack of available personnel.

A committee from the society is working with the architect on the plans for the new psychopathic hospital at the University of Maryland Hospital and Medical School. The hospital will provide private and public beds for white and Negro men and women and about 30 beds for white and Negro children. In all 125 beds will be provided. The director of the new department will also be professor of psychiatry in the university medical school.

Massachusetts

The Massachusetts Society for Mental Hygiene is participating in a lecture series for labor-union counselors who in turn will serve as aids in referring cases to social agencies within the unions. The society also participated in a course for rehabilitation agents given at the Harvard Summer School session.

A member of the staff was a guest speaker on the radio program of the American Legion Auxiliary.

For several months the society has had a special committee, under the chairmanship of Dr. Erich Lindemann, working on mental hygiene in industry.

A recent number of the *New England Journal of Medicine* contains an article by Dr. Vernon P. Williams, the society's consulting psychiatrist, on "Psychiatry: Rehabilitation."

Washington

The Washington Society for Mental Hygiene has assisted in the organization of a local unit which will be known as the Tacoma Mental Hygiene Committee. The Tacoma committee will be affiliated with the state society and is the first unit to be organized under the new state-wide expansion program. It is anticipated that this development will stimulate the organization of other local units which will, in turn, strengthen the state society.

Publication of the society's bi-monthly news bulletin was resumed with the September issue. The new series, called "Mental Health To-day" was introduced with a lead article, *A Definition of Mental Hygiene*, by Dr. S. Harvard Kaufman, Director, Mental Hygiene Section, State Department of Health. The editorial article, *The Mental Hygiene Society and Community Needs*, was contributed by Dr. Ralph M. Stolzheise, President of the Washington Society.

New Publication

The American Prison Association, of 135 East 15th Street, New York 3, N. Y., has issued a "Cumulative Analytical Index to the 'Proceedings' of the American Prison Congress, covering the years 1935–1943, inclusive." The index was compiled by Herman K. Spector, Chief Librarian of the Department of Correction, New York City. Copies are available without charge (except four cents for postage) to university, college, and public libraries and to public welfare, correctional, and penal institutions.

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INDEX TO VOLUME XXIX

INDEX TO AUTHOR, TITLE, AND SUBJECT

N

O

P

Q

R

BOOK REVIEWS

LISTED BY AUTHORS OF BOOKS